FY 2008 Annual Evaluation Report

To the Interagency Collaboration and Services Integration Commission (ICSIC)

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Submitted to

Office of the Deputy Mayor for Education
John A. Wilson Building
1350 Pennsylvania Avenue NW, Suite 303
Washington, DC 20004

Submitted by

Development Services Group, Inc.
7315 Wisconsin Avenue, Suite 800 East
Bethesda, Maryland 20814
http://www.dsgonline.com

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1. Executive Summary

The Interagency Collaboration and Services Integration Commission (ICSIC) was established by Title V of the Public Education Reform Amendment Act of 2007. As its full name suggests, ICSIC was established to foster interagency collaboration that would strengthen services integration. In turn, the enhanced services integration would improve outcomes, in six agreed-upon goal areas, for children and youth in the District of Columbia.

To increase the likelihood of success, the legislation requires that ICSIC concentrate on identifying and implementing programs that have been demonstrated, by rigorous research, to be effective in other communities. (Such programs are often referred to as "evidence based" because they have produced positive outcomes documented by scientific evidence.) The legislation requires, furthermore, that ICSIC evaluate the outcomes of those programs for children and youth in the District.

ICSIC was established to improve interagency collaboration, services integration, and outcomes for the District's children and youth. The Mayor has chaired every meeting.

The formation and work of ICSIC is a key part of a larger educational reform initiative currently under way in the District. This initiative is driven by a desire to ensure that all District youth receive the education and supports they need, to prepare them for work or for college. The initiative emphasizes a) choosing appropriate strategies that have been proven by research to be effective, b) implementing those strategies in the appropriate systems and settings in the District, and c) verifying that those strategies, when implemented, are generating the intended outcomes in the District. The approach taken by ICSIC to select, implement, and evaluate those strategies is bold and unique. Under the leadership of the Deputy Mayor for Education, and with the regular participation of the Mayor and the leaders of many child-serving agencies, ICSIC is fostering collaboration across a broad range of agencies that have responsibilities that touch on the health, well-being, and education of District children and youth. In this way, ICSIC is bringing a new direction to educational reform in the District. Indeed, ICSIC is seeking to ensure that all District youth get the education and supports they need, by enabling them to take advantage of improvements that are being implemented throughout multiple systems in the District, under this wide-ranging reform initiative.

This report documents the steps ICSIC has taken to date, after being in operation for just over a year, and presents the results of preliminary evaluation efforts.

The Interagency Collaboration and Services Integration Commission

ICSIC Members and Meetings

Pursuant to the legislation, ICSIC was established and conducts meetings of its members to improve interagency collaboration, services integration, and outcomes for the District's children and youth. The members of ICSIC include the directors of the following city agencies that affect the health and well-being of children and youth in the District of Columbia: Office of the State

Superintendent of Education, District of Columbia Public Schools, Public Charter School Board, Office of the Deputy Mayor for Education, Department of Human Services, Child and Family Services Agency, Department of Youth Rehabilitation Services, Department of Corrections, Department of Health, Department of Mental Health, Metropolitan Police Department, Court Social Services Agency, Office of the Attorney General, Criminal Justice Coordinating Council, Department of Parks and Recreation, District of Columbia Public Library, Family Court, and Superior Court of the District of Columbia.

In addition, the Mayor has invited representatives from other District agencies to observe and participate in the monthly ICSIC meetings. These other agencies include the Department of Employment Services, the Children & Youth Investment Trust Corporation, the Department of Disability Services, the Office of the Chief Financial Officer, and the Office of the Chief Technology Officer.

ICSIC meetings have been chaired by the Mayor. They are planned, coordinated, and staffed by the Office of the Deputy Mayor for Education (DME). Participation at the meetings has been very good, and the Mayor has attended and chaired every meeting. As a result, ICSIC has been able to provide effective oversight of the actions required by the legislation.

ICSIC has provided effective oversight and support of the following goals for children and youth in the District:

- Children are ready for school.
- Children and youth succeed in school.
- Children and youth are healthy and practice healthy behaviors.
- Children and youth engage in meaningful activities.
- Children and youth live in healthy, stable, and supportive families.
- All youth make a successful transition into adulthood.

ICSIC's Legislatively Mandated Activities

Pursuant to the legislation, ICSIC has developed an information-sharing memorandum of agreement, identified a comprehensive multidisciplinary assessment instrument, begun to develop integrated service plans for individual children and their families, developed a management information system that enables interagency exchange, implemented evidence-based programs, and begun to conduct an annual independent evaluation.

These activities are designed to help the District achieve six goals for children and youth: 1) Children are ready for school, 2) children and youth succeed in school, 3) children and youth are healthy and practice healthy behaviors, 4) children and youth engage in meaningful activities, 5) children and youth live in healthy, stable, and supportive families, and 6) all youth make a successful transition into adulthood.

Evidence-Based Programs for District of Columbia Public Schools

To achieve these goals, and consistent with the legislation, ***ICSIC identified, selected, and implemented five evidence-based programs for children and youth in the District: DC START, Second Step®, LifeSkills® Training, Primary Project, and School Resource Officer Training.***

These programs, or their components, have been proven by rigorous research to be effective in other communities. The programs, therefore, offer great promise of being effective in the District, as long as they are implemented with a high degree of fidelity (that is, faithfulness) to the original program model. These programs are now being rolled out in a planned implementation strategy, following an extensive training regimen for each program.

Early Results

Early results from surveys, focus groups, interviews, and program data are very promising with respect to the implementation of the evidence-based programs and the trainings for those programs. For example:

Evaluations of training participants for the evidence-based programs show that 246 hours of training were provided during 22 trainings conducted by credentialed, experienced trainers who are highly proficient in their fields. A total of 316 schoolteachers, police officers, school staff, administrators, and others took part in these training programs. Highlights of the evaluations are as follows:

- ***New staff were thoroughly trained on the DC START model's procedures, assessment instruments, and database.*** One hundred percent of the DC START staff felt that they were proficiently trained and ready to implement the program. The clinicians' preparatory training was sufficiently thorough to ensure fidelity to the DC START model.

- ***More than 100 School Resource Officers and school security personnel were trained***. They reported that the training made them better prepared to identify safety issues in their schools, more equipped to keep their schools safe, better able to apply Crime Prevention Through Environmental Design techniques, better able to conduct safety audits, and more engaged with youth.

Nearly 250 hours of training were provided during 22 training events conducted by nationally recognized, credentialed, trainers. More than 300 DCPS, MPD, and DMH staff received intensive training.

- ***Teachers and other school personnel who participated in the LifeSkills® Trainings and Second Step® trainings reported that the trainings prepared them to implement the programs in their classrooms***, that they responded positively to the role-playing scenarios, and that the training taught them skills they could use in the classroom.

- ***A qualified coordinator and 24 child associates were hired by the Department of Mental Health to implement Primary Project in 12 schools.*** One training was held on Oct. 6 and 7, in which 19 child associates were trained. The child associates reported extremely favorably about the training experience. Additional child associates were trained in a second training on December 8 and 9.

A focus group of clinicians who completed a training on the DC START program gave very positive responses to the program, the training, and the trainers. They expressed great

Early results of DC START implementation indicate that appropriately qualified staff were hired and employed in a timely fashion by the DME and that the ongoing technical assistance to prepare schools has been effective.

enthusiasm about the fact that the program focuses on the "whole" child in the context of his or her family, school, and larger community, not just on the child as a student in a school. They gave high marks for the two evidence-based approaches taken by DC START, namely, cognitive-behavioral therapy and child-centered play therapy.

Early results of DC START program implementation indicate that appropriately qualified staff were hired and employed in a timely fashion. Project administrators put in place the salient elements of the DC START model. The project rollout and ongoing technical assistance to prepare schools for making appropriate referrals have been effective. ***During the first eight months of operation, the pilot project served a client population of 109 children*** and their families with complex service needs who are likely to benefit from the intervention. Information on outcomes will be available in the next annual report.

Early results of Second Step® implementation show that 12 schools have two or more teachers implementing the Second Step® curriculum. At this early stage of implementation, ***it is estimated that up to 2,000 children are in classrooms where Second Step® is being taught.***

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Plans for Fiscal Year 2009

Plans for next year include the following activities: continued implementation of DC START and the SRO training, startup of Primary Project, accelerated rollout of LifeSkills® and Second Step®, implementation of several new evidence-based programs to be selected by ICSIC, provision of additional trainings on those programs, and implementation of data collection needed to conduct structured evaluations of each program and of the ICSIC process as a whole.

Preliminary Findings

In addition to continuing current activities, plans for FY 2009 include implementation of several new evidence-based programs and structured program evaluations.

The District of Columbia—under the leadership of the Mayor, and with his extensive participation—has initiated and is implementing a very broad, well-structured process, under the supervision of ICSIC, for the selection, implementation, and evaluation of evidence-based programs that have a real chance of making a difference in the lives of the District's children and youth. Because of the regular meetings of ICSIC—with the involvement of the Mayor, the Deputy Mayor for Education, and the key agency heads—this process has a chance of achieving effective interagency collaboration that can bring about real services integration. In addition, the selection and implementation of proven programs and program components increase the likelihood that the results of this effort will be positive.

The ICSIC and the DME can take pride in some major accomplishments so far:

- They have established a serious and credible process, with monthly meetings that involve the Mayor, the Deputy Mayor for Education, and the key child-serving and other agency heads.

- They have maintained the focus of that process on the achievement of broad, crosscutting goals for the District's children and youth.

- They have successfully negotiated a memorandum of understanding among all the participating agencies, to ensure that they will share appropriate data about children and ensure the confidentiality of that information. .

- They have successfully identified and begun to implement five evidence-based programs that, in whole or in part, have been widely and rigorously studied, and widely hailed for their excellence and effectiveness.

- They have hired appropriately qualified staff for DC START and Primary Project and successfully begun to train teachers, clinicians, School Resource Officers, and other staff on how best to implement these programs.

- They have provided continuing oversight, hands-on supervision, and onsite technical assistance for those who are working on these programs.

- They have overseen the collection of a variety of preliminary evaluation data, both qualitative and quantitative, which indicate that the processes, the trainings, and the implementation and evaluation of the programs are proceeding well.

- And they have directed the development of a plan for more rigorous evaluation of the ICSIC process and of the implementation and outcomes of the evidence-based programs.

Preliminary Recommendations

At this early stage in the implementation of these programs, several steps should be considered by ICSIC and the District, to ensure the effectiveness of these efforts:

- ICSIC and DME should consider how best to encourage greater engagement on the part of some school administrators, particularly school principals, in the implementation of ICSIC-sponsored programs, especially LifeSkills® Training, Second Step®, and the School Resource Officer programs.

- ICSIC and DME should also continue to seek ways to maintain a high level of support among teachers and other implementers, so that they can maintain appropriate levels of fidelity to the evidence-based programs they are helping to carry out.

- ICSIC should ensure that the experience and voices of frontline staff (e.g., School Resource Officers) continue to be included (perhaps even more than before) in the planning and implementation process. Many of these staff have valuable hands-on experience with the situations faced by different schools, and with the community and family contexts that contribute to school problems.

- ICSIC should consider how to provide stronger direction and coordination for the primary prevention programs—such as Second Step®, LifeSkills®, and the School Resource Officer programs—that are being implemented in many schools.

- After the first round of program implementation has been completed in spring 2009, ICSIC should, where needed, broaden the spectrum of services available in each of the mandated areas and continue to develop services that meet the needs of the District's children and families. The following kinds of additional programs could be considered for implementation: primary prevention programs to increase family resilience, secondary prevention programs to increase school attendance, and tertiary prevention programs especially to reduce truancy and juvenile violence and delinquency.

- ICSIC should seek to identify those schools and school programs that are effectively addressing difficult student, home, school, and community issues and, wherever possible, build on those successes.

Concluding Note

The ICSIC membership, structure, and processes have so far been effectively conceived and implemented, and ICSIC is succeeding in bringing a new direction to educational reform in the District. Under the leadership of the Deputy Mayor for Education—and with the regular participation of the Mayor and the leaders of many child-serving agencies—ICSIC is fostering collaboration across a broad range of agencies that have responsibilities that touch on the health, well-being, and education of District youth. Indeed, ICSIC is seeking to ensure that all children and youth get the education and supports they need, by enabling them to take advantage of improvements that are being implemented throughout multiple systems in the District, under this reform initiative.

ICSIC and the District deserve high marks for this successful beginning to such a wide-ranging collaborative effort.

The early results of the implementation of the evidence-based programs, and of the training to support those programs, have been positive and promising. ICSIC and the District deserve high marks for a successful beginning to such a wide-ranging collaborative effort.

2. The Interagency Collaboration and Services Integration Commission

Membership

The Interagency Collaboration and Services Integration Commission (ICSIC) was established by Title V of the District of Columbia Public Education Reform Amendment Act of 2007 (the Act; see appendix A). The Commission, widely known as ICSIC, is chaired by the Mayor. As required by the Act, ICSIC includes the directors of the following District agencies that serve children:

- Office of the State Superintendent of Education
- District of Columbia Public Schools
- Public Charter School Board
- Office of the Deputy Mayor for Education
- Department of Human Services
- Child and Family Services Agency
- Department of Youth Rehabilitation Services
- Department of Corrections
- Department of Health
- Department of Mental Health
- Metropolitan Police Department
- Court Social Services Agency
- Office of the Attorney General
- Criminal Justice Coordinating Council
- Department of Parks and Recreation
- District of Columbia Public Library
- Family Court, Superior Court of the District of Columbia

In addition, the Mayor has invited representatives from other District agencies to observe and participate in the monthly ICSIC meetings. These other agencies include the Department of Employment Services, the Children & Youth Investment Trust Corporation, the Department of Disability Services, the Office of the Chief Financial Officer, and the Office of the Chief Technology Officer.

Meetings

ICSIC meetings are planned, coordinated, and staffed by the Office of the Deputy Mayor for Education (DME). They are chaired, however, by the Mayor. The Mayor has demonstrated a high level of commitment to this cross-agency collaboration by attending every meeting. Each meeting also has included high-level participation from directors (or appropriate designees) of the member agencies. Active participation is required, since ICSIC members are responsible for implementing actions related to the work of the Commission.

Each ICSIC meeting has concentrated on one of the following six citywide goals for children and youth:

- Goal 1: Children are ready for school.
- Goal 2: Children and youth succeed in school.
- Goal 3: Children and youth are healthy and practice healthy behaviors.
- Goal 4: Children and youth engage in meaningful activities.
- Goal 5: Children and youth live in healthy, stable and supportive families.
- Goal 6: All youth make successful transitions into adulthood.

ICSIC has held 16 meetings since August 2007, devoted to the goals as follows:

- Goal 1: Aug. 15, 2007; Feb. 21, 2008; Sept. 17, 2008
- Goal 2: Sept. 19, 2007; March 20, 2008; Oct. 15, 2008
- Goal 3: Oct. 17, 2007; April 22, 2008; Dec. 2, 2008
- Goal 4: Nov. 28, 2007; May 21, 2008; Dec. 17, 2008
- Goal 5: Dec. 19, 2007; June 18, 2008
- Goal 6: Jan. 16, 2008; July 16, 2008

The ICSIC meetings have been consistently well attended by the required agency heads or their designees. At more than 60 percent of the meetings, attendance from the 13 mandated child-serving agencies has been at or above 70 percent. The average rate of mandated child-serving agency participation in ICSIC meetings is 69 percent. (Attendance may vary based on the relevance to each agency of the goal or goals being discussed at particular meetings.) Considering that the attendees are agency heads, this appears to be a high attendance rate, attesting to the importance that the member agencies place on collaboration through ICSIC.

ICSIC meetings are recorded, and the video recordings are posted on the Web site of the Deputy Mayor for Education (http://www.dme.dc.gov) or on the Web site of the Office of Cable Television (http://www.oct.dc.gov).

Legislatively Mandated Activities

ICSIC's central responsibilities are to implement the legislative mandates of the Act. In addition, ICSIC addresses and implements other ongoing initiatives not required by that legislation. Listed below are the major legislatively mandated activities and duties of ICSIC as articulated in the Act:

- Develop an information-sharing agreement
- Develop procedures and protocols for safeguarding confidential and other participant-related information, documents, files, electronic communications, and computer data
- Identify a comprehensive, multidisciplinary assessment instrument that shall be used by school-based clinicians
- Develop integrated service plans for individual children and their families
- Develop a management information system that enables interagency exchange

- Implement evidence-based programs
- Conduct an annual independent evaluation of the effectiveness of the programs supported, facilitated, or overseen by ICSIC.

In Title V (Section 505) the Act states that ICSIC must complete the first three mandates within the first 90 days—that is, by Sept. 12, 2007. Those mandates have been fulfilled, as required and on time.

The mandates, and the status of their implementation, are briefly discussed below.

Develop an Information-Sharing Memorandum of Agreement

ICSIC staff, in consultation with all member-agency directors and general counsels, developed an information-sharing memorandum of agreement (MOA) that calls for the collection of data from each member agency on any individual child in the DC START program with consent from a parent or guardian (see appendix B). The MOA was signed by every member agency and includes a consent-and-waiver form that must be completed by the parent or guardian before services can begin (see appendix C).

ICSIC developed a memorandum of agreement for the collection of data from member agencies on individual children in the DC START program with consent from a parent or guardian.

Develop Procedures and Protocols for Safeguarding Confidential Information

The MOA describes procedures and protocols for safeguarding confidential information in files and a database. The Office of the Chief Technology Officer assisted ICSIC in adapting a database that stores confidential information and provides case management and treatment plan tools for school-based clinicians working with the confidential data. This database was transferred from the Partnership for Results (the successful initiative that set the precedent for ICSIC).

Identify a Comprehensive, Multidisciplinary Assessment Instrument

The Deputy Mayor for Education, in August and September 2007, convened a panel of government officials and external experts to select a multidisciplinary assessment to be used by ICSIC in the DC START program. Representatives from the Department of Mental Health, the District of Columbia Public Schools, the Office of the State Superintendent of Education, Georgetown University, the Children's National Medical Center, and the National Association of School Psychologists reviewed several validated assessments to determine the extent to which they met the legislative requirements, the applicability to possible ICSIC programs in the District of Columbia, and the process by which the assessment is implemented. Following this review the panel recommended the use of the Well-Being Assessment Instrument (Well–BAT). The Well–BAT has since been incorporated into the launch of DC START.

The Well–BAT, designed to promote service planning for vulnerable children, takes into account individual, community, family, and school factors. A national panel of experts reviewed several hundred instruments as part of the development of the Well–BAT. This instrument is unique, multidisciplinary, and sensitive to the early onset of problems and dysfunctions. It examines 37 areas related to service needs in three general categories: level of functioning, environmental influences, and personal development.

ICSIC accomplished all three major objectives—establishing the MOA, setting up procedures for protecting confidential information, and identifying a comprehensive, multidisciplinary assessment instrument—within the required 90 days.

All three of the above tasks—establishing the memorandum of agreement, setting procedures for protecting confidential information, and identifying the Well–BAT—were accomplished within the required 90 days.

Develop Integrated Service Plans for Individual Children and Their Families

DC START clinicians formulate an integrated service plan, based on the Well–BAT assessment, for each child and family. This plan calls for delivering services that are comprehensive and provided without interruption, and for eliminating duplication of services. The plan is implemented and tracked through the Children At-Risk Interagency (CHARI) database and supported through meetings held at regular intervals with individuals involved in the care plan. These individuals include the clinician, program supervisor, parent/caretaker, and trainers (for cognitive behavioral therapy, or CBT, and child-centered play therapy, or CCPT).

Develop a Management Information System That Enables Interagency Exchange

ICSIC developed a comprehensive memorandum of understanding (MOU) that protects families' privacy rights by setting forth the rules for how exchanges of information can occur. The speed with which the MOU was developed and signed reflects the commitment of ICSIC members to act expeditiously to ensure that conditions support the rollout of programs for District youth and their families.

Based on this MOU, the ICSIC has been able to support the implementation and use of the CHARI database. CHARI was designed to be "one stop" resource that supports program evaluation and accountability by 1) allowing clinicians to record and regularly update information on clients and track their progress, and 2) permitting the collection and analysis of data needed for program evaluation. Certain information related to demographics, family background, and education is entered into CHARI when a case is first opened. On a regular basis, the clinician also is required to enter information concerning case progress; this information is categorized into areas such as treatment plan and goals, service referrals, alcohol/substance abuse, and mental health and medical events. CHARI specifies timeframes for intervention activities and sends reminders. It also includes data integrity checks that ensure data is being collected and entered systematically. These features facilitate evaluation of the program's effectiveness.

Select and Implement Evidence-Based Programs

The Act also requires implementation of age appropriate evidence-based programs that are and implemented to serve children and their families. According to the legislation, "evidence-based program" means a program that

- Has been affirmatively evaluated by an independent agency with demonstrated expertise in evaluation
- Demonstrates effectiveness in accomplishing its intended purposes and yields statistically significant supporting data
- Has been replicated in other communities with a level of effectiveness comparable to that indicated in the evaluation required by the first item in this bulleted list

Types of programs mentioned in the legislation include

- Early childhood psychological, social, and emotional development
- School-based violence and substance abuse prevention
- Social and emotional learning assistance
- Family resiliency and strengthening assistance
- Services that are designed to reduce local reliance on out-of-home placement of children under 18

Prevention programs can be divided into primary, secondary, and tertiary prevention programs. Researchers in education, health, juvenile delinquency, mental health, violence, and other fields have established discipline-specific criteria for what constitutes prevention. Although there is no definition of these three levels of prevention that is universally accepted in all disciplines, the general principles described below can be used to clearly distinguish between the levels.

PRIMARY PREVENTION PROGRAMS

Primary prevention programs have no eligibility criteria for involvement and are designed to reach most or all persons in a specified age range. They are intended to prevent problems before onset and are generally designed to address root causes, conditions, and environments proactively to eliminate the possibility of disease, violence, substance use, and the like.

SECONDARY PREVENTION PROGRAMS

Secondary prevention programs are targeted interventions with clear eligibility criteria that concentrate on a rather large subset of children and youth in early onset of problematic behavior or disease who, absent the intervention, are at risk of engaging in more serious or problematic behaviors or developing more serious mental health or health problems. They are generally brief interventions (e.g., less than six months in duration). In addition, the interventions usually are less intensive—that is, the dosage is relatively infrequent (e.g., weekly sessions).

TERTIARY PREVENTION PROGRAMS

Tertiary prevention programs are targeted interventions with clear eligibility criteria that concentrate on a small subset of children and youth to correct or treat a fully developed problem in the least restrictive environment possible. Absent the intervention, these children and youth will most likely engage in increasingly severe behavior or become so unhealthy that a restrictive and/or highly intensive therapeutic intervention will be required to address the problem. Tertiary prevention programs are longer and more intensive than secondary prevention initiatives.

In the past year, ICSIC has implemented five programs that fall into these categories: DC START (**DC STudent Assessment and Resilience Team**), Second Step®, LifeSkills® Training, School Resource Officer (SRO) Training, and Primary Project. (Chapter 3 describes the programs in detail.)

During its first year, ICSIC supported the implementation of five programs:

- DC START (DC STudent Assessment and Resilience Team)
- Primary Project
- Second Step®
- LifeSkills® Training
- School Resource Officer (SRO) Training

The five programs were carefully chosen based on input from a variety of sources including 1) conversations with ICSIC members, principals, school officials, and youth, and 2) data on current issues facing the District's children and families. All five programs are grounded in research and meet the Act's requirements for evidence-based programs (see **table 2.1**).

Careful consideration was given to the speed with which programs could be rolled out and to the number of schools or students that should be targeted in the first phase. In most cases, program start-up and implementation require a great deal of time and resources. Thus staff were deliberate in selecting programs and planning implementation. ICSIC staff worked closely with the District of Columbia Public Schools (DCPS) to select schools for each program and, in some cases, to determine the specific number of students who would be served. When making decisions about programs in schools, staff considered the capacity of school personnel, other mental health programs in the school, geographic area, and school population needs.

Additional planning was conducted with parent organizations and trainers who were chosen through a national selection process for each program. Plans for each program were developed in partnership with local officials and national experts. This planning was conducted to ensure that implementation would occur with a high degree of fidelity to the program models.

Table 2.1. ICSIC Evidence-Based Programs Implemented in FY 2008

Categories	Primary Prevention	Secondary Prevention	Tertiary Prevention
Early Childhood (social/emotional, school preparedness, school adjustment)	Second Step® K–3	DC START K–3 Primary Project	
Juvenile Violence and Delinquency	School Resource Officer Training LifeSkills® Training Second Step® K–8	DC START	
Social /Emotional (Mental Health)	Second Step® LifeSkills® Training	Primary Project DC START	
Family Resilience/ Strengthening		DC START	
Truancy/Attendance	School Resource Officer Training	DC START	
Health	LifeSkills® Training		
Substance Use/Abuse	LifeSkills® Training School Resource Officer Training	DC START	
Reduce Reliance on Out-of-Home Placement		DC START	

A deliberate implementation process was put in place for each program. For example, DC START, a highly complex program, began first in two schools in spring 2008. Two clinicians identified for the program participated in an intensive training in Auburn, N.Y. (site of the original model), to become knowledge experts in the model design and program. The work of these two clinicians provided an opportunity to demonstrate implementation of DC START in DCPS on a smaller scale before an expanded effort began in fall 2008.

The careful selection of teachers to implement Second Step® also highlights the deliberate nature of program planning. ICSIC and DCPS staff asked principals to recommend teachers who would be motivated and interested in implementing Second Step® in the classroom. The first round of training was offered to these teachers to get the program started in schools at the beginning of the fall 2008 school year. More trainings will be provided later for other staff interested in Second Step® for their students.

Conduct an Annual Independent Evaluation

In addition to the 90-day requirements and the program development requirements, ICSIC must conduct an annual independent evaluation of the effectiveness of the programs supported,

facilitated, or overseen by ICSIC. It must report, on an annual basis, within 90 days after the end of the fiscal year, to the Mayor and the Criminal Coordinating Justice Council on the status and progress of work undertaken to meet ICSIC's objectives including the annual independent evaluation of program effectiveness. Through a competitive bidding process, ICSIC contracted with Development Services Group, Inc. (DSG) to evaluate ICSIC programs over five years. The award was made on Sept. 15, 2008.

ICSIC contracted for an independent evaluation of the effectiveness of the programs supported, facilitated, or overseen by the Commission.

DSG has the special expertise needed to conduct rigorous evaluations for ICSIC, having performed program evaluations in education, juvenile justice, and other areas for more than two decades. Together, Project Director Marcia Cohen and Deputy Project Director Judith Pokorni have more than 40 years' experience conducting process and outcome evaluations. DSG also has a long history of expertise in evidence-based programs, especially in identifying and evaluating programs for at-risk youth, and in helping communities determine how best implement those programs. DSG created and operates for the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, the *Model Programs Guide* (*MPG;* see http://www.dsgonline.com/mpg2.5/mpg_index.htm), which is a searchable database of evidence-based programs. The MPG serves as the "what works" database behind the Office of the First Lady's Helping America's Youth Web site and the Federal Information for Youth Web site.

Highlights of Recent Achievements Related to Six Goals for Children and Youth

In June 2007 the Mayor made a commitment to retain the previous administration's six citywide goals for children, youth, and families. These six goals provide a framework for ICSIC's efforts. ICSIC uses the goals to set policy and budget priorities, track data on key interagency indicators, and coordinate initiatives and services among agencies. Each goal requires collaboration and coordination among and between agencies. ICSIC includes the directors of the District's major human service and child-serving agencies. Interagency efforts under the six goals were initiated by the directors of ICSIC member agencies and are facilitated by support staff. ICSIC's work to accomplish the goals is ongoing. Selected highlights of achievements over past year are described below.

ICSIC uses the six citywide goals to set policy and budget priorities, track data on key interagency indicators, and coordinate initiatives and services among agencies.

Goal 1. Children Are Ready for School

The District is committed to providing high-quality early childhood programming in community-based and school settings. Historically, the District has not had a way to measure program quality or student progress in relation to State-level early learning standards. Over the past year, ICSIC agencies collaborated to develop and pilot a school preparedness assessment, which will be rolled out citywide next school year. Teachers will use this observation tool to measure student development. From this process, they will be able to assess whether students are meeting

benchmarks and whether to modify their instruction to meet the needs of the students in the classroom, and to improve early childhood programming.

Goal 2. Children and Youth Succeed in School

During summer 2008 the District of Columbia school system prepared to receive new students at more than 20 schools as a result of the Chancellor's plan to reorganize the school system and consolidate schools. The previous spring, to ensure that the consolidations would go smoothly and that consolidated schools would be prepared to begin the year productively, the Office of the Deputy Mayor for Education had established an interagency working group. It included representatives from DCPS, the Department of Transportation, the Metropolitan Police Department, the Department of Parks and Recreation, and the Office of the Ombudsman. Meeting each week throughout the summer, the working group concentrated on developing a comprehensive planning framework and strategies for individual schools to address issues related to student safety, the combining of different populations, school culture, parental involvement, safe transportation routes. For each school, the group developed a plan that covered school crossing guard assignments, bus and walking routes, intervention and safety plans for students from rival communities, and engagement activities for students, staff, and parents.

According to the National Center for School Engagement, school success is related to three elements: attendance, achievement, and attachment. ICSIC agencies have concentrated on improving student attendance as a main priority under Goal 2. In December, truancy regulations—developed in collaboration with the Office of the State Superintendent of Education, DCPS, the Public Charter School Board, the Child and Family Services Agency, Court Social Services, the Criminal Justice Coordinating Council, and numerous community-based organizations—were presented to the State Board of Education for approval. These interagency partnerships also have led to other services and supports in the schools (such as mental health services and school nurses) to address the root causes of truancy (which often are associated with factors external to the classroom such as poor health,). At the same time, DCPS focuses on improving the quality of classroom education to help address the other two elements of school success (achievement and attachment).

Goal 3. Children and Youth Are Healthy and Practice Healthy Behaviors

Recognizing the impact that poor health makes on academic outcomes, ICSIC—with leadership from the Department of Health—developed the Child Health Action Plan. Released in February 2008, the plan has guided cross-agency collaboration and work related to the health of children in eight areas: obesity, sexual health, asthma, substance abuse, lead, well-child visits, infant mortality, and oral health. Coordination and collaboration on children's health issues takes place through a school health working group convened by the Office of the Deputy Mayor for Education, and with representation from the Department of Health, the Department of Mental Health, DCPS, and the Office of the State Superintendent of Education. This senior-level working group ensures that agencies working on children's health issues are concentrating on priorities of the Child Health Action Plan and

ICSIC, with leadership from the Department of Health, developed the Child Health Action Plan released in February 2008.

removing barriers to health services for children.

One highlight of the Child Health Action Plan is its work in addressing the crisis in sexual health with new partnerships between the Department of Health, the Department of Employment Services, the Department of Parks and Recreation, and DCPS to conduct health workshops and screenings for sexually transmitted diseases (STDs) for youth in summer jobs and high school students. Another is the collaboration it has generated between the Department of Health, the Office of the State Superintendent of Education, DCPS, and the public charter schools to implement a Condom Availability Policy, ensuring that school nurses are able to distribute condoms in both DCPS and public charter schools. To combat the childhood obesity problem in the District, the Department of Health and the Department of Parks and Recreation have teamed up to implement a worksite wellness program, which is currently being piloted in the Child and Family Services Agency, the Office of the State Superintendent of Education, and the Department of Health. Additionally, the Department of Health is collaborating with the Department of Consumer and Regulatory Affairs and community-based organizations to increase neighborhood-based access to healthy food choices and nutrition education through the Healthy Corner Store Initiative.

Goal 4. Children and Youth Engage in Meaningful Activities

Under ICSIC's auspices, DCPS, the Department of Parks and Recreation, the Children & Youth Investment Trust Corporation, and community-based organizations developed a committee of out-of-school time providers, which has created a new, improved structure for out-of-school time at DCPS schools that has maximized resources and improved the quality of programming for students. In school year 2007–08, DCPS had more than 800 partners providing out-of-school time services to students in a variety of capacities. This committee has since vetted providers wishing to serve students in SY 2008–09 to ensure that they will provide effective services. The committee has matched providers with schools to meet the needs of the students and community and to ensure that each school has variety in programming, including both educational and enrichment options. Historically, a lack of coordination has led to some schools having numerous partnerships and services, and others having nothing. As a result of this interagency coordination, DCPS has an out-of-school time program in every school and is able to provide direction to providers about increasing capacity and responding to specific areas of need.

> As a result of ICSIC interagency coordination, DCPS has an out-of-school-time program in every school, and is able to provide direction to providers about increasing capacity and responding to specific areas of need.

Goal 5. Children and Youth Live in Healthy, Stable, and Supportive Families

Poverty is a leading contributor to instability at home and in family life. The American Community Survey reported in 2007 that 22.7 percent of children under 18 are living below the Federal Poverty Level in the District. ICSIC—in partnership with the Department of Human Services, the Department of Employment Services, the University of the District of Columbia, the Office of the Attorney General, and DCPS—is working to increase the resource base of thousands of Temporary Assistance to Needy Families households. These efforts will include

linking families to existing public benefits for which they are eligible and providing job training and employment opportunities. Human service agencies have also come together to develop a child abuse–prevention plan that responds to the many needs of families and fosters healthy bonds among family members. These are the first steps in a concentrated effort to empower parents to strengthen and stabilize their families.

Goal 6. All Youth Make Successful Transitions Into Adulthood

Engaging disconnected youth—youth who are not in school and not working—requires a strong multiagency effort. Several agencies—including the Department of Employment Services, the Department of Youth Rehabilitative Services, the Child and Family Services Agency, and both the DCPS and public charter schools—have collaborated on reengaging these young people in school, in work, or through a mentor. Since ICSIC began, these groups have expanded opportunities for disengaged youth by opening the Youth Engagement Academy, a school that currently serves 60 overage and undercredited ninth graders through alternative learning opportunities and internships, and developing training and employment opportunities in partnership with the Office of the Deputy Mayor for Planning and Economic Development and other government service agencies.

Summary

Throughout 2008, ICSIC held ongoing discussions about the appropriate indicators (see **table 2.2**) for a multiagency group to be held accountable for the six citywide goals. Discussion topics included appropriate baseline and target measures for each indicator. Tracking this data provides additional information on the kinds of initiatives and programs that should be prioritized by ICSIC member agencies.

Table 2.2. Six Citywide Goals for Children and Youth and Interagency Indicators

Children Are Ready for School	Children and Youth Succeed in School	Children and Youth Are Healthy and Practice Healthy Behaviors	Children and Youth Engage in Meaningful Activities	Children and Youth Live in Healthy, Stable, and Supportive Families	All Youth Make Successful Transitions Into Adulthood
Interagency Indicators:	***Interagency Indicators:***	***Interagency Indicators:***	***Interagency Indicators:***	***Interagency Indicators:***	***Interagency Indicators:***
Low birth weight	Attendance rates/graduation rates	Child and adolescent obesity rates	Year-round youth employment rate	Child poverty rate	Number of youth out of school and out of work
School readiness	Literacy	STD rates	Juvenile crime rate	Youth permanency rate	

3. Evidence-Based Programs for District of Columbia Public Schools

This chapter discusses the selection and the implementation of evidence-based programs for the Interagency Collaboration and Services Integration Commission (ICSIC) initiative in District of Columbia schools. First, a brief description is provided of the process used to select the five evidence-based programs that are now being carried out in the schools (DC START, Primary Project, Second Step®, LifeSkills®, and School Resource Officers). Next, background information is presented for each program that covers the following topics: program overview, previous research, and status of program implementation (i.e., program sites, staff qualifications and responsibilities, staff training, and activities undertaken to date).

Selection Process

The selection process for the programs chosen by ICSIC and the Mayor is grounded in the mandate, articulated in the Public Education Reform Amendment Act of 2007, that the Commission must address "the needs of at-risk children by reducing juvenile and family violence and promoting social and emotional skills among children and youth through the oversight of a comprehensive integrated service delivery system."

The legislation recognizes and responds to past efforts to address these needs. Clearly, many well-intentioned efforts have been made to help District youth. However, while many of the implemented programs have promised results, few positive, measurable outcomes have been documented. For this effort, therefore, the legislation specifies that prevention and intervention programs should be selected only if they are *evidence based*—that is, only if the programs have been proven to work in diverse communities. To ensure that the programs do not degenerate into well-intentioned but ineffective efforts, the legislation also specifies that the programs must be independently evaluated. The evaluations are to determine a) whether the programs have been implemented with fidelity to the original program models, and b) whether the programs are achieving outcomes in the District that are comparable with the outcomes previously documented in the research literature.

Identifying promising and effective prevention and intervention programs has become easier, given resources such as the *Model Programs Guide* (*http://www.dsgonline.com/mpg2.5/mpg_index.htm*), which is supported by the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. These resources describe the key components of intervention and prevention programs, and rate their effectiveness based on the rigor of studies conducted to evaluate the programs.

Many of the prevention and intervention programs now available build on the framework of the *risk and protective factors* model. This model addresses correlations between risk and protective factors in the lives of youth, on the one hand, and negative behavioral outcomes such as substance abuse, sexual risk, school dropout, and violence, on the other.

Hawkins, Catalano, and colleagues (Hawkins, Catalano, and Miller, 1992; Catalano and Hawkins, 1995; Hawkins et al., 2000) synthesized the risk factor research into the widely used and fairly comprehensive approach that has become a template for prevention-program funding across multiple agencies in the United States. In brief, the model lays out a multilevel algorithm of factors (or forces) that, in the course of youth development, are said to increase or decrease the likelihood that a youth will engage in problem behaviors, such as violence, delinquency, substance abuse, school dropout, and HIV/AIDS risk behavior.

Exposure to *risk factors* increases the likelihood of problem behavior, while exposure to *protective factors* reduces the likelihood of problem behavior, by buffering the risk factors. Under the Hawkins and Catalano model, risk factors are organized into multiple domains (e.g., individual, peer, school, community, society/environment). Protective factors under this model are not as well specified, although others who have followed the same general approach have placed greater emphasis on various protective factors. Such programs concentrate more on enhancing protective factors and less on reducing risk factors; they often use the concept of *resiliency* to characterize these protective qualities. In this approach, behavioral outcomes are said to be determined by the degree of resiliency that exists in the face of risk factors that may be present (Benard, 1991).

Exposure to *risk factors* increases the likelihood of problem behavior, while exposure to *protective factors* reduces the likelihood of problem behavior, by buffering the risk factors.

In selecting from the various available programs, ICSIC and the Mayor wanted to ensure a full range of services that could benefit all age groups in the school system. Since the needs of youth vary widely, primary, secondary, and tertiary programs were considered. Primary prevention programs, such as LifeSkills® Training and Second Step®, are delivered to all students regardless of their risk for engaging in problem behaviors. Secondary prevention programs are delivered to a smaller group of youth who have been identified through assessments as being at risk and who demonstrate mild to moderate problems. Secondary prevention programs selected for the first round of evidence-based program implementation include Primary Project and DC START. Tertiary interventions are targeted at an even smaller subset of youth, who have even more serious difficulties and are in need of intensive help. There are no tertiary programs funded by ICSIC at this time.

Selected Programs

After considering the various options, ICSIC agreed on five programs that would address various barriers faced by District youth:

- **DC START (DC STudent Assessment and Resilience Team),** a research-based model for providing school-based mental health services with a strong record of promoting positive social and emotional outcomes and engendering student resilience.
- **Primary Project**, a school-based early intervention and prevention program that addresses the social and emotional needs of children in kindergarten through third grade who have social or emotional school-adjustment difficulties, but no serious dysfunction.

- **Second Step®,** a violence prevention curriculum designed to reduce impulsive and aggressive behavior in children by increasing their social competency skills**.**
- **LifeSkills® Training,** a classroom-based tobacco, alcohol, and drug abuse prevention program for upper elementary and junior high school students.
- **School Resource Officer (SRO) Training**, a program designed to help SROs (specially trained law enforcement officers assigned to schools) reduce juvenile misbehavior, delinquency, and arrests, and increase protective factors. The program is grounded in research-based principles and the extensively proven community-policing model.

Placement of programs in schools requires an ongoing process, due to the complexities involved in working with a large system. At first, DCPS was interested in placing LifeSkills® Training in some of the middle schools. However, through a partnership with American Lung Association, ICSIC was able to offer LifeSkills® Training in all DCPS schools with grades 6–8. Likewise, some schools slated to deliver the Primary Project program could not do so due to inadequate space; as a result, some adjustments were made. **Tables 3.1, 3.2, and 3.3** show the planned implementation of programs in elementary, middle, and high schools, respectively, during the fall of school year 2008–09.

Detailed descriptions of the five evidence-based programs follow the tables.

Table 3.1. Planned Implementation of Evidence-Based Programs in Elementary Schools/Educational Centers

Elementary Schools/ Educational Centers	Second Step®	Primary Project	DC START	LifeSkills® Training	SRO (number of officers)
Aiton Elementary School 533 48th Place NE		**Primary Project**			
Barnard Elementary School 430 Decatur Street NW			**DC START**		
Brightwood Educational Center (PK–8) 1300 Nicholson Street NW	**Second Step®**			**LifeSkills® Training**	
Browne Educational Center (PreK–8) 850 26th Street NE	**Second Step®**	**Primary Project**		**LifeSkills® Training**	**SRO (1)**
Burroughs Educational Center (PK–8) 1820 Monroe Street NE	**Second Step®**			**LifeSkills® Training**	
Burrville Elementary School 801 Division Avenue NE		**Primary Project**			
Draper Elementary School 908 Wahler Place SE				**LifeSkills® Training**	
Emery Educational Center 1720 First Street NE	**Second Step®**			**LifeSkills® Training**	
Francis–Stevens Educational Center 2425 N Street NW	**Second Step®**			**LifeSkills® Training**	**SRO (1)**
Garrison Elementary School 1200 S Street NW		**Primary Project**			
Hamilton Educational Center 1401 Brentwood Pkwy. NE					**SRO (1)**
Langdon Educational Center 1900 Evarts Street NE	**Second Step®**			**LifeSkills® Training**	
LaSalle–Backus Educational Center 501 Riggs Road NE	**Second Step®**			**LifeSkills® Training**	**SRO (2)**
Leckie Elementary School 4201 Martin Luther King Jr. Avenue SW			**DC START**		
Malcolm X Elementary School 1351 Alabama Avenue SE			**DC START**		
Marshall Educational Center 3100 Fort Lincoln Drive NE	**Second Step®**	**Primary Project**		**LifeSkills® Training**	**SRO (1)**
(Martin Luther) King Elementary School 3200 Sixth Street SE			**DC START**		

Table 3.1. Planned Implementation of Evidence-Based Programs in Elementary Schools/Educational Centers

Elementary Schools/ Educational Centers	Second Step®	Primary Project	DC START	LifeSkills® Training	SRO (number of officers)
Meridian Public Charter School 1328 Florida Avenue NW		**Primary Project**			
Miner Elementary School 601 15th Street NE		**Primary Project**			
Noyes Educational Center 2725 10th Street NE	**Second Step®**			**LifeSkills® Training**	
Oyster–Adams Bilingual School, 2801 Calvert Street NW and 2020 19th Street NW				**LifeSkills® Training**	
Randle Highlands Elementary School 1650 30th Street SE				**LifeSkills® Training**	
Raymond Educational Center 915 Spring Road NW	**Second Step®**			**LifeSkills® Training**	
Shaed Educational Center 301 Douglas Street NE	**Second Step®**			**LifeSkills® Training**	
Simon Elementary School 401 Mississippi Avenue SE			**DC START**		
Stanton Elementary School 2701 Naylor Road NE		**Primary Project**			
Takoma Educational Center 7010 Piney Branch Road NW	**Second Step®**			**LifeSkills® Training**	**SRO (1)[a]**
M.C. Terrell/McGogney Elementary School 3301 Wheeler Road SE		**Primary Project**			
Truesdell Educational Center 800 Ingraham Street NW	**Second Step®**		**DC START**		
Tubman Elementary School 3101 13th Street NW		**Primary Project**			
Turner Elementary School 3264 Stanton Road SE		**Primary Project**			
Walker–Jones/R.H. Terrell Educational Center (PK–8) 100 L Street NW	**Second Step®**			**LifeSkills® Training**	**SRO (2)**
Webb/Wheatley Elementary School 1375 Mount Olivet Road NE		**Primary Project**		**LifeSkills® Training**	
West Educational Center 1338 Farragut Street NW	**Second Step®**			**LifeSkills® Training**	
Whittier Educational Center 6201 Fifth Street NW	**Second Step®**			**LifeSkills®**	

[a]Takoma Educational Center and Roosevelt Senior High School share SROs.

Table 3.2. Planned Implementation of Evidence-Based Programs in Middle Schools				
Middle Schools	**Second Step®**	**LifeSkills® Training**	**DC START**	**SRO**
Deal Middle School 3815 Fort Drive NW		**LifeSkills® Training**		**SRO (2)**
Eliot–Hine Middle School 1830 Constitution Avenue NE		**LifeSkills® Training**		**SRO (2)**
Francis–Stevens Educational Center 2425 N Street NW	**Second Step®**	**LifeSkills® Training**		**SRO (1)**
Hardy Middle School 1819 35th Street NW		**LifeSkills® Training**		**SRO (1)**
Hart Middle School 601 Mississippi Avenue SE		**LifeSkills® Training**		**SRO (3)**
Jefferson Middle School 801 Seventh Street SW		**LifeSkills® Training**		**SRO (2)**
Johnson Middle School 1400 Bruce Place SE		**LifeSkills® Training**		**SRO (3)**
Kelly Miller Middle School 301 49th Street NE		**LifeSkills® Training**		**SRO (2)**
Kramer Middle School 1700 Q Street SE		**LifeSkills® Training**		**SRO (2)**
Lincoln Middle School 3101 16th Street NW		**LifeSkills® Training**		**SRO (4)[a]**
MacFarland Middle School 4400 Iowa Avenue NW		**LifeSkills® Training**	**DC START**	**SRO (2)**
Ronald H. Brown Middle School 4800 Meade Street NE				**SRO (2)**
Shaw at Garnet–Patterson Middle School 2001 10th Street NW		**LifeSkills® Training**		**SRO (3)**
Sousa Middle School 3650 Ely Place SE		**LifeSkills® Training**		**SRO (2)**
Stuart–Hobson Middle School 410 E Street NE		**LifeSkills® Training**		**SRO (1)**
Winston Educational Center 3100 Erie Street SE				**SRO (2)**

[a]Lincoln Middle School and Bell High School share SROs.

Table 3.3. Planned Implementation of Evidence-Based Programs in High Schools		
High Schools	**LifeSkills® Training [c]**	**SRO**
Anacostia Senior High School 1601 16th Street SE		**SRO (4)**
Ballou Senior High School 3401 Fourth Street SE		**SRO (4)**
Ballou STAY Senior High School 3401 Fourth Street SE		**SRO (1)**
Banneker Senior High School 800 Euclid Street NW		**SRO (1)**
Bell High School 3101 16th Street NW	**LifeSkills® Training**	**SRO (4)[b]**
Cardozo Senior High School 1200 Clifton Street NW	**LifeSkills® Training**	**SRO (5)**
Coolidge Senior High School 6315 Fifth Street NW		**SRO (4)**
Dunbar Senior High School 1301 New Jersey Avenue NW		**SRO (4)**
Eastern Senior High School 1700 East Capitol Street NE		**SRO (4)**
Ellington School of the Arts 3500 R Street NW		**SRO (1)**
Luke C. Moore Academy Senior High School 1001 Monroe Street NE		**SRO (1)**
McKinley Technology High School 151 T Street NE		**SRO (2)**
Phelps Architecture, Construction, and Engineering High School 704 26th Street NE		**SRO (1)**
Roosevelt Senior High School 4301 13th Street NW		**SRO (3)[c]**
School Without Walls Senior High School @ Logan 215 G Street NE		**SRO (1)**
Spingarn Senior High School 2500 Benning Road NE		**SRO (3)**
Spingarn STAY 2500 Benning Road NE		**SRO (1)**
Woodrow Wilson Senior High School 3950 Chesapeake Street NW		**SRO (4)**
Woodson at Fletcher–Johnson 4650 Benning Road SE		**SRO (4)**

[a] SY08-09 implementation of LifeSkills Training has primarily focused on middle schools.

[b] Bell High School and Lincoln Middle School share SROs.

[c] Roosevelt Senior High School and Takoma Educational Center share SROs.

DC START

PROGRAM OVERVIEW

DC START is a research-based model for providing school mental health services using a system-of-care approach to the delivery of human services. DC START is designed primarily to foster positive social, emotional, and educational development. Because it is grounded in the science of what works, DC START has a strong record of promoting positive social and emotional outcomes, as well as engendering student resilience. DC START addresses issues that many young students face, such as anger management difficulties, behavior/conduct problems, depression, anxiety, alcohol and other drug issues, feelings of isolation, excessive shyness, serious aggressiveness with peers or family, chronic school absences, feelings of worthlessness, or sudden changes in personality. To address these concerns, DC START provides a highly structured set of interventions for elementary school and middle school-age children with complex needs.

DC START addresses issues many young students face, such as anger management difficulties, behavior/conduct problems, depression, anxiety, alcohol and other drug issues, feelings of isolation, excessive shyness, serious aggressiveness with peers or family, chronic school absences, feelings of worthlessness, or sudden changes in personality.

Launched as a pilot program in two District of Columbia elementary schools in April 2008**,** DC START uses research-based principles in a system-of-care approach to human services delivery. The DC START program includes four core components:

1. Multidisciplinary screening and assessment of participants
2. Development of integrated service plans for clients and their families
3. Clinician use of one of two evidence-based therapeutic interventions—Cognitive-Behavioral Therapy (CBT) and Child-Centered Play Therapy (CCPT)—depending on the child's age and level of development
4. Documentation and monitoring of service delivery using an interagency database known as the Children At-Risk Interagency (CHARI) database

REVIEW OF PREVIOUS RESEARCH

DC START is based on the Mobile Outreach Services Team (MOST) model implemented in the Auburn Enlarged City School District in New York State. The MOST model was developed by the Partnership for Results and the Cayuga County Community Mental Health Center. Youth Policy Institute, Inc. (YPI) evaluated the program.

Research has found that the two key therapeutic modalities of the MOST program (CBT and CCPT) are effective interventions for a variety of problems.

Studies of CBT provide consistent empirical evidence that the therapy is associated with significant and clinically meaningful positive changes, particularly when it is provided by experienced practitioners (Waldron and Kaminer, 2004). CBT has been successfully applied across settings (e.g., schools, support groups, prisons, treatment agencies, community-based organizations, churches) and across ages and roles (e.g., students, parents, teachers). It has been

shown to be relevant to persons with different abilities and from diverse backgrounds. The strategies of CBT have succeeded in forestalling the onset of problem behaviors among young people, reducing their severity, and long-term consequences.

CCPT has been shown effective in treating a wide variety of children's problems and in building self-esteem and more mature, prosocial behaviors. It has been applied successfully to different client populations (e.g., children of alcoholics, multiply handicapped children, mentally retarded children) and has been found to reduce children's aggressive behavior (Johnson et al., 1999).

The MOST program integrates these two therapies with interdisciplinary screening and assessment and provides a mechanism (the CHARI database) for data-driven monitoring. Fidelity to essential components of the MOST intervention was measured by YPI using retrospective survey instruments administered to clinicians nine months posttraining. Measuring fidelity is an essential component of program evaluation, because deviations from the model may affect efficacy. The Child-Centered Play Therapy Implementation Checklist was developed based on findings from the fidelity measurement field; the Checklist gauges whether clinicians implemented 18 essential elements of CCPT, which are grouped to evaluate fidelity in four program areas: screening, assessment, service planning, and monitoring. Use of the Checklist allowed an assessment of whether disparate outcomes from multiple sites could be attributed to site-specific variables or lack of adherence to the model. It also provided detailed information on problems in model adherence that could be addressed through additional training. YPI's evaluation of the MOST intervention has shown high fidelity in program implementation and high parent satisfaction.

MOST program outcomes were assessed using clinicians' assessments of progress toward goals, a mental health pretest/posttest, and changes in school behaviors as measured by referrals for discipline. Of the closed cases within the evaluation timeframe (n=153), 59.5 percent of the students and their families (n=91) completed the entire intervention (November 2007). For these clients, clinicians reported that they either met or made significant progress in meeting 45.9 percent of their treatment goals (primarily those related to mental health and education) and minor/moderate progress in another 44.5 percent of their treatment goals. Those who demonstrated the most severe internalizing and externalizing behaviors on average experienced the most improved outcomes. A preservice and postservice assessment for closed cases showed, on average, a 30.6 percent improvement in their mental health status; scores at postservice indicated that many clients no longer needed mental health services. Referrals for discipline were 35 percent and 37 percent lower during and posttreatment, compared with a comparable timeframe before the intervention.

A roughly 2:1 male-to-female participation rate in MOST programs was found. The intervention included a diverse population facing risk factors across multiple domains.

Surveys were used to assess parent satisfaction with the integrated care plans and the MOST program (YPI, 2008). It is important to assess parent/caregiver satisfaction with the program, since the intervention's success largely depends on the caregivers' understanding of the program components, their involvement in the program, and their reinforcement of therapeutic strategies. Surveys were given to parents/caretakers during 2007 and 2008. The return rate for both surveys

was about 50 percent of the closed and completed cases. This high rate of response was attributed to the MOST clinician's personal request that the parent complete the survey. During both survey periods, parents expressed exceptionally high levels of satisfaction with the MOST program and its staff.

IMPLEMENTATION STATUS

Schools

The following schools have been selected for implementation of DC START:

1. Barnard Elementary School
2. Leckie Elementary School
3. Malcolm X Elementary School
4. Simon Elementary School
5. Truesdell Educational Center
6. Martin Luther King Jr. Elementary School
7. MacFarland Middle School

The two schools that started in April 2008 were Barnard and Truesdell. The remaining five began in August.

DC START Staff

Hiring of personnel for the DC START project began in April 2008 when two clinicians were recruited to begin the program's pilot phase. The DC START coordinator and five additional clinicians were hired in July 2008. All clinicians and the coordinator are employees of the Office of the Deputy Mayor for Education.

DC START Coordinator and Qualifications. The DC START coordinator must be a Licensed Independent Clinical Social Worker (LICSW) in the District. This person should have a working knowledge of Cognitive-Behavioral Therapy and Child-Centered Play Therapy, five years of experience supervising clinicians, experience working with school-based programs, and good communication and writing skills. The coordinator, among other duties, handles the implementation and expansion of DC START, oversees the DC START clinicians to ensure model adherence, oversees specialized trainings in CCPT and CBT, and serves as liaison between DC START and local schools. The coordinator also supports ICSIC sustainability efforts.

Ms. Debra Rager, LICSW, has been hired as the DC START coordinator. Ms. Rager meets or exceeds all qualifications for this position. She has extensive experience working with children and their families and helping coordinate services to support treatment goals. Her experience as an educator and clinical instructor is particularly relevant to this position since she has not only used play therapy with clients but also led trainings on play therapy for the Yale Child Study Center. She has supervised clinical staff for many years. Ms. Rager holds an MSW from Boston University.

DC START School Clinicians and Qualifications. Each DC START clinician must be a master's-level clinician capable of assessing children and providing appropriate prevention and

intervention treatment. Clinicians must develop and monitor an integrated service plan for each child and family, using the CHARI database. The clinicians also develop discharge plans that may include follow-up services. They provide year-round care and their caseload may include up to 25 children and their families at one time. They deliver CBT and CCPT services in a school-based setting, though interventions last no more than 21 sessions per child.

The DC START coordinator and clinicians all meet or exceed the education and experience requirements of their positions.

The school clinicians hired for DC START all meet or exceed the requirements for this position. Each has a master's degree. Six of the seven clinicians hold MSW degrees; one holds an MS degree in Clinical Psychology. Some are newly credentialed at the master's level, but all bring experience working with youth and their families. All have provided therapy to youth and several have direct experience with play therapy; many have coordinated service plans for children, and all have worked on assessments. Several have worked as school social workers in District schools or with the DC foster care system, and thus bring systems knowledge to the position. The school clinicians' previous experience represents a major commitment to helping youth overcome a wide range of obstacles so they can lead productive lives and realize more and more of their potential. The school clinicians are highly qualified to work with the DC START target population.

Staff Training

A strong emphasis was placed on providing comprehensive staff training during the initial phase of DC START. Staff were thoroughly trained in a timely fashion on the model's procedures, assessment instruments, and database. Project administrators put in place the core elements of the DC START model. ICSIC contracted with five master trainers to provide initial and ongoing training:

- Robin Kincaid, MSW, LMSW and Philip Uninsky, J.D., of the Partnership for Results, Inc., Auburn, N.Y., provided training on the protocols used in the MOST model, including documentation of services through the CHARI database.

- Jodi Mullen, Ph.D., of the State University of New York at Oswego, provided Child-Centered Play Therapy training.

- Michael Maurer, MSW, LCSW, a contractor for Partnership for Results, comes to the District monthly to provide Cognitive-Behavioral Therapy training.

- Rob Scuka, Ph.D., M.S.W., LCSW–C, executive director of National Institute of Relationship Enhancement and a member of NIRE's faculty, meets with clinicians monthly to provide additional training in Child-Centered Play Therapy training to all DC START clinicians.

The first two clinicians to be hired participated in a three-day intensive training program delivered by Partnership for Results staff in April 2008. The training concentrated on program

philosophy, program treatment modalities (Child-Centered Play and Cognitive-Behavioral Therapies), program policies and protocols, and documentation.

Once the DC START coordinator and the additional clinicians were hired, all seven clinicians and the coordinator attended a two-week training program held Aug. 4–15 in Washington, DC, conducted by the same individuals who trained the first two clinicians. The training was organized as follows:

- Four days concentrated on the MOST model being implemented as DC START and on documentation using the CHARI database (master trainers: Robin Kincaid and Philip Uninsky).

- Three days concentrated on Cognitive-Behavioral Therapy, brain development, core philosophy, and core therapy skills (master trainer: Michael Maurer).

- Three days concentrated on Child-Centered Play Therapy, its core skills (reflection and tracking), and practice through role-play (master trainer: Jodi Mullen).

Throughout the training program, emphasis was placed on team building among the staff.

The extensive components on CBT and CCPT during the training in August are augmented with a 1½-hour training session for each therapy every month. Expert trainers in the specific therapy deliver these group trainings. The DC START coordinator also provides a weekly 1½-hour group technical assistance session and a weekly one-hour individual supervision session to each clinician. Topics covered during the weekly group sessions include DC START protocols, introducing the program to school staff and parents, stress management, and community resources. Additional sessions presented by others have included topics such as the Child and Family Services Agency–mandated reporter training, community resources, and CHARI database documentation.

Activities to Date

Pilot Program. From April to July 2008, the pilot phase of the DC START program took place at Truesdell and Barnard. The groundwork for program implementation was established through interactions between the school principals, a representative of the Office of the Deputy Mayor for Education (DME), and a child development specialist contracted by that office. The program was explained, and the principals agreed to provide office space for the clinician assigned to their school.

Upon agreement of the principal, each clinician established an office in the school that contained locked file cabinets for student records, play and other therapy equipment, and a laptop computer for record keeping. The school provided furniture.

The clinicians communicated with principals and other key school staff and began receiving referrals from teachers. Program protocols, described below, were implemented and children began receiving services during the summer months that included home visits and clinical sessions. All clinical sessions during the summer were held at Barnard Elementary School, since

this building was open for summer school while Truesdell Elementary was closed. Sessions for the children who participated in the pilot program continued during the 2008–09 school year.

Full Program. Once the coordinator and additional clinicians were hired and trained, five additional schools began the DC START program: Simon, Leckie, Martin Luther King, and Malcolm X Elementary Schools and MacFarland Middle School.

Once again, groundwork was laid at schools through visits to principals and school staff by a representative of the Office of the DME, the ICSIC consultant, and the DC START coordinator. Principals provided a furnished office. Appropriate supplies, equipment, and toys were obtained through the Office of the DME.

During the first six weeks, clinicians and the coordinator met with staff, attended other school meetings, and provided teachers with information on the program. They followed the protocol below, which is based on the procedures used in the MOST model.:

- Referrals can be made by a teacher, a counselor, other school staff, a parent, or a student. The teacher and one other person complete the Observation Checklist at the time of case opening, noting the indicators of potential need. (They will complete this checklist again when the case closes).

- Additional information is gathered from other sources, including during the school Student Support Team (SST) meetings.

- Once a student is selected to receive services through the DC START program, a parent signs a release form allowing DC START staff to contact the parent.

When staff receive permission to contact the parent, at least one home visit is scheduled to gather further information using the following forms (see Appendix D for copies of these instruments):

  - *Consent and Waiver Form*—for permission to provide DC START services.
  - *Universal Information Form*—for family demographic and contact information.
  - *Youth Checklist*— completed by youth and caregiver for background information on the child or youth.
  - *Exposure to Violence Form*—for documenting the child's or youth's exposure to violence.
  - *Youth Pediatric Symptom Checklist*—used by the clinician to score the youth checklist.
  - *The Personal Experience Screening Questionnaire (PESQ)*—filled out 45 days after a case opens and then a second time at closing, if the youth is a substance abuser.

Once this information is gathered and scored, the clinician begins completing and scoring the Well-Being Assessment Instrument (Well–BAT). The Well–BAT is completed within 45 days of a case opening and then again at closing. The instrument helps clinicians

- Identify a child/youth/s risk and protective factors
- Decide whether further assessment is needed
- Identify a mental health diagnosis
- Develop the child/youth's treatment plan

Children At-Risk Interagency (CHARI) Database. CHARI was designed as a "one-stop" resource that supports program evaluation and accountability by 1) allowing clinicians to record and regularly update information on their clients and track their progress, and 2) permitting the collection and analysis of data needed for program evaluation. Certain information (related to demographics, family background, and education) must be entered when a case is first opened. On a regular basis, the clinician also is required to enter information concerning case progress; this information is categorized into areas such as treatment plan and goals, service referrals, alcohol/substance abuse, and mental health and medical events. CHARI specifies timeframes for intervention activities and sends reminders. It also includes data integrity checks that ensure data is being collected and entered systematically.

During the pilot and into the first months of the 2008–09 school year, the CHARI database developed at Partnerships for Results in Auburn, N.Y., was adapted for use in DC START. Computers for clinicians were purchased and software installed to facilitate data entry. Because of connectivity problems and intermittent software problems, clinicians have been coming to the DC START coordinator's office to enter data directly into CHARI. It is expected that once the Web-based version of the CHARI database begins to operate in spring 2009, clinicians will enter data at their respective sites through the Internet.

Primary Project

PROGRAM OVERVIEW

Primary Project is a school-based intervention and prevention program that addresses the social and emotional needs of children in kindergarten through third grade who have social or emotional school-adjustment difficulties.

Primary Project (formerly the Primary Mental Health Project, or PMHP) is a school-based early intervention and prevention program that addresses the social and emotional needs of children in kindergarten through third grade who have social or emotional school-adjustment difficulties (but no serious dysfunction). Primary Project is used to augment school-based mental health efforts for children who could benefit from additional help. Implementing Primary Project involves paraprofessional "child associates" who work more intensively with students.

The program uses early screening tools with all children to identify those in need of additional supports early in their school career. Typical candidates include children who are acting out, display mild aggression, are anxious or withdrawn, or have learning problems that interfere with progress in school. The teachers, parents, and school counselors of each student collaborate to develop an intervention plan that establishes goals for the student's treatment. The core of the intervention is the creation of a strong relationship with the child associate, who meets with the student for weekly, 25- to 45-minute, one-on-one counseling sessions during 12 to 15 weeks a year. The child associate meets with the student in a structured playroom environment in

expressive play sessions intended to reinforce and build on the child's strengths. Progress is assessed during regular meetings between the child associate and school mental health professionals and midintervention progress reviews.

Program materials include a variety of informational booklets and manuals such as

- *School-Based Prevention for Children at Risk*
- *Primary Mental Health Project: Program Development Manual*
- *The Primer: A Handbook for Establishing a PMHP Program*
- *Behind These Young Faces: The Primary Mental Health Project*
- *Screening and Evaluation Measures and Forms: Guidelines*
- *Supervision of Paraprofessionals: Guidelines for Mental Health Professionals*

The intervention has been shown to work with tribal, urban, suburban, and rural populations. It has been used successfully with Hispanic, American Indian/Alaskan, Asian/Pacific Islander, white, and African-American populations.

Primary Project has been designated a "Promising Prevention Program" by the U.S. Department of Education's Safe, Disciplined and Drug-Free Schools Expert Panel. It has been recognized as one of five exemplary prevention programs in the Nation in the *U.S. Surgeon General's Report on Mental Health* (December 1999). It is highlighted by the *National Registry of Evidence-based Programs and Practices*, a searchable online registry of Substance Abuse and Mental Health Services Administration (SAMHSA), and the *Model Programs Guide*, a searchable online registry supported by the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention. Both registries include interventions that have been reviewed and rated by independent reviewers.

REVIEW OF PREVIOUS RESEARCH

A recent evaluation of a Primary Project site in Hennepin County, Minn., compared baseline data from program participants with their combined data from the 2001–02 and 2002–03 school years (Demanchick and Johnson, 2004). Data was collected from teachers at baseline and program completion using the T–CRS (Teacher–Child Rating Scale) 2.1, a tool that measures student competencies and problem behaviors through scaled questions addressing four competency areas: task orientation, behavior control, assertiveness, and peer social skills. The sample consisted of 54 percent males and 46 percent females. Fifty-three percent of the children lived in middle-income homes, 31 percent in lower income homes, and 11 percent in poverty-level homes. Forty-six percent of the children in the sample were in prekindergarten or kindergarten, 26 percent were in first grade, 21 percent in second grade, and 7 percent in third grade. The comparison of pretest and posttest T–CRS results showed statistically significant changes as a result of the program in all four competency areas across the county. Program students made significant improvements in task orientation, specifically in working more independently and completing tasks faster. In behavior control, program students showed increased coping skills and lower levels of aggressiveness, and produced fewer disruptions. In assertiveness, students had improved participation in activities, were better at expressing ideas, and showed increased leadership and decreased shyness. Improvements in peer sociability included increases in the quality of peer relationships and improved social skills.

Another study assessed program impacts in Jefferson County, Ky. (Cowen, 2001). The sample for this study consisted of 610 students participating in the program in 12 schools in the Jefferson County Public School District. Of these, 299 took both pretests and posttests. The sample was made up of roughly equal proportions of students in kindergarten, first grade, second grade, and third grade. Forty-seven percent were female. The ethnic breakdown was 55 percent African-American, 38 percent white, and 6 percent "other." Analysis was based on data collected using the T–CRS. Jefferson County study researchers found improvements similar to those in the Hennepin County study, from pretest to posttest in all competency areas at both the State and district level.

Several other evaluations of Primary Project provide evidence of improved school adjustment and decreases in problem behaviors for treatment children. One control group study, with 600 children from 18 school sites randomly assigned to immediate intervention and delayed treatment groups, showed statistically significant decreases in adjustment problems for children receiving program services compared with children waiting for services. Another wait control group design, which employed a three-month follow-up measure, demonstrated for the treatment group a decline in teacher ratings of learning problems and shy/anxious behaviors, and an increase in task orientation and peer social skills. One of the matched comparison group evaluations showed a decrease in adjustment problems and an increase in adaptive competencies after one school year in favor of the treatment group. Long-term effects were found in a follow-up study of fourth through sixth graders two to five years after the intervention. Posttest-only results showed treatment children to be better adjusted than a demographically comparable group of current problem children, based on teacher identifications and ratings, in a statistically significant finding.

IMPLEMENTATION STATUS

Schools

Beginning in January 2009, Primary Project will be implemented by the Department of Mental Health (DMH) at the following schools:

1. Aiton Elementary School
2. Browne Educational Center (PK–8)
3. Burrville Elementary School
4. Garrison Elementary School
5. Harriet Tubman Elementary School
6. M.C. Terrell/McGogney Elementary School
7. Meridian Public Charter School (Early Childhood Unit–8)
8. Miner Elementary School
9. Stanton Elementary School
10. Thurgood Marshall Educational Center (PK–8)
11. Turner Elementary School
12. Webb/Wheatley Elementary School

Primary Project Staff

DMH began hiring staff for Primary Project program in summer 2008 and has almost completed filling all positions. The staff needed for this program include a Primary Project manager and 24 child associates. It is anticipated that two child associates will be located in most schools. The coordinator and child associates are DMH employees.

Primary Project Manager and Qualifications. The Primary Project manager must have a knowledge of a health science field and be currently licensed to practice in the District of Columbia. The manager will help select and supervise 24 part-time paraprofessionals who will use child-led play to provide support to children. The manager must facilitate the selection of playroom space and furnishings, and monitor budget and reimbursement processes. The manager will act as a spokesperson and Primary Project advocate in the school district and community and ensure the completion of evaluation forms, records, reports.

The Primary Project manager has extensive experience with multisite projects and will oversee 24 child associates trained in Child-Centered Play Therapy.

Donna Coakley was hired as the Primary Project manager. She meets or exceeds all the qualifications for this position. Her extensive experience as a mental health clinician, case manager supervisor, and early childhood educator make her uniquely qualified to carry out the multiple and diverse duties associated with this position. She brings directly relevant experience in coordinating program events (e.g., completion of evaluations, maintenance of records) that support compliance and adherence to a program's requirements. In addition, she has deep experience supervising teams. Her most recent work experience has been in Washington, DC, so she also brings relevant systems knowledge that will support the work of Primary Project in the District.

Child Associates and Qualifications. Child associates are paraprofessionals who work under the direct supervision of a certified school mental health professional. Child associates should have experience working with children, preferably in a school setting, and a high school diploma, and they should demonstrate empathy and a willingness to be trained and supervised by a mental health professional. They will engage in nondirective play with participating children in half-hour sessions throughout the school year, meet weekly with a mental health professional for supervision, and complete all required documentation. They will work a maximum of 18 hours per week and carry a caseload of 12–15 cases. When possible, the child associates are identified within the local school community, since these adults are often compatible with the cultural and racial/ethnic values of the children in the community.

The résumés of the child associates reflect a wide variety of backgrounds and work and life experience; some of the child associates exceed the requirements of the position. Although not required for the position, all hold a high school degree, many from local schools. Several also have completed college courses or have college degrees. Many have worked with children in past positions and they possess a wide diversity of work and life experiences.

Staff Training

A strong emphasis was placed on providing comprehensive staff training during this phase of Primary Project implementation. ICSIC contracted with Mary Ann Peabody, who is certified by the Children's Institute as a master trainer, to provide initial and ongoing training.

The first day of training is primarily didactic. It gives an overview of Primary Project and discusses barriers to learning. Other topics include the six core components of Primary Project, the targeted age range, screening, team approach, and the role of the child associate and supervisor. Also covered in the first day are program measures and evaluations, and strategies for integrating the intervention with other programs.

The second day is devoted to the play-based, child-centered approach at the heart of Primary Project and includes demonstrations and opportunities for practicing and receiving feedback from the trainer. The second day also covers supervision, includes an outline of the year, and provides a walk-through of the measures. Participants have the opportunity to discuss setting limits, and to role-play.

The first training was held for new child associates and school mental health professionals on Oct. 6–7, 2008. A second training for the newest associates took place Dec. 8–9, 2008. Associates who have already been trained received a refresher course in the afternoon of Dec. 9.

Activities to Date

The screening of first graders has been completed at most schools and submitted for scoring; kindergarten students will be screened after the winter break.

Twelve schools have been identified for implementation of Primary Project; all schools already have a mental health professional on staff. Some of the schools initially slated for implementation had to be replaced because of space issues. All principals were contacted by Barbara Parks, Clinical Program Administrator, Prevention and Early Intervention Programs, Department of Mental Health, or Laura Kiesler of the Office of the Deputy Mayor for Education. Principals received information on the intervention, the target population, the new staff to be located at the school, and the space requirements for the intervention.

Space in each school has been set aside for the child associates to conduct child-led play sessions. This space has been appropriately carpeted, furnished, and outfitted with a variety of toys.

Primary Project entails the systematic screening of all children in a target age group—in this case, all first graders. This helps identify children who will most benefit from Primary Project, and those in need of more intensive help. Children who can most benefit from Primary Project are those experiencing adaptive or interpersonal problems, such as mild aggression, acting out, shyness, anxiety, or withdrawnness. To screen the children, teachers are using the AML–R Behavior Rating Scale (a standardized screening tool). Most of the 12 schools have completed their screenings, which have been sent to the Children's Institute in New York State for scoring. The scores will determine how many youth at each school will be offered enrollment in the program; it is expected that up to 40 percent will screen positive. Active consent must be secured

from the parent or guardian of each child; the Primary Project manager or the child's teacher will be responsible for securing consent.

In addition to the screening score, a child's referral to the program requires independent information, such as behavioral observation by a school mental health professional. In an assignment conference, Primary Project staff, participating teachers, and others as needed (e.g., school nurse, reading teacher) discuss relevant information and draw up a composite sketch of each child's school adjustment/educational difficulties. Then, they begin to develop the intervention plan. By end of this process, a list has been compiled of children at each school who will be referred to Primary Project, and the parental consent process begins.

The Background Information Form is completed, and before the child begins services, the classroom teacher completes the Teacher–Child Rating Scale 2.1 (T–CRS). This instrument assesses task orientation, behavior control, assertiveness, and peer social skills. Next, the program team finalizes the individualized treatment plan. Most schools will begin offering active services in January, once the scoring and consent processes are complete. The child associate meets weekly for 30 minutes with each child for 12–15 weeks, unless the child is referred for an additional round of 12–15 weeks. The child associate is expected to keep a child log, which documents the number and duration of sessions, as well as how the sessions are conducted. Conferences are held regularly to monitor the progress of the individualized treatment plan.

At the end of the intervention, the teacher completes another T–CRS. Sometimes, an Associate (A)–CRS is also completed. The supervisor completes a Professional Summary Report. (See Appendix D for copies of these instruments.)

Typically, two rounds of Primary Project sessions will be delivered in one year once the program begins in January 2009.

Second Step®: A Violence Prevention Curriculum

PROGRAM OVERVIEW

The Second Step® program is designed to reduce impulsive and aggressive behavior in children by increasing their social competency. Children learn empathy, impulse control, problem solving, and anger management.

Second Step®: A Violence Prevention Curriculum (referred to as Second Step®) is an evidence-based program designed to reduce impulsive and aggressive behavior in children by increasing their social competencies. The curriculum's foundation rests on three essential social competencies: a) empathy, b) impulse control and problem solving, and c) anger management. Students are taught core social and emotional skills to reduce impulsive, high-risk, and aggressive behaviors and to increase social/emotional competencies. Teachers are trained to draw children's attention to the positive results of their prosocial behaviors to promote each child's positive identity. The program uses peer interactions and adult modeling to foster the development of a positive identity. The net result of full implementation of Second Step® is an improved school culture that integrates academics with social and emotional learning.

Second Step® has been successful with urban, suburban, and rural populations. The program has proven effective in geographically diverse cities in the United States and Canada, in classrooms varying in ethnic/racial makeup, and in schools with students of varied socioeconomic status. It has been used successfully with Hispanic, American Indian/Alaskan, Asian/Pacific Islander, white, and African-American populations.

The target population includes children in preschool through middle school, ages 4 to 14. The program is composed of three grade-specific curricula: preschool/kindergarten (PK), elementary school (grades 1–5), and middle school (grades 6–8). The curricula are designed for teachers and other youth service providers to present in a classroom or other group setting. A parent education component, "A Family Guide to Second Step®" for PK through grade 5, is also a part of the program.

The Second Step® elementary curriculum consists of 15 to 22 thirty-five-minute lessons per grade level. Lessons are taught once or twice a week. Group discussion, modeling, coaching, and practice are used to increase students' social/emotional competencies, risk assessment skills, decision-making ability, self-regulation, and positive goal setting. The lesson content varies by grade level and is organized into three skill-building units covering the following:

- *Empathy training* teaches young people to identify and understand their own emotions and those of others.

- *Impulse control and problem solving* helps young people choose positive goals, reduce impulsiveness, and evaluate consequences of their behavior in terms of safety, fairness, and impact on others.

- *Anger management* enables youth to manage emotional reactions and engage in decision-making when they are highly aroused.

The Second Step® curriculum for middle school students is composed of eight to fifteen 50-minute lessons per grade level organized into four units:

- Unit 1 is centered on knowledge and describes violence as a societal problem.

- Unit 2 trains students in empathy and encourages emotionality through learning to find common ground with others, avoiding labeling and stereotyping, using "I" messages, and active listening.

- Unit 3 combines anger management training and interpersonal problem-solving for reducing impulsive and aggressive behavior in adolescents.

- Unit 4 applies the skills learned in previous units to five specific situations: making a complaint, dealing with peer pressure, resisting gang pressure, dealing with bullying, and diffusing a fight. Students learn new behaviors through modeling by participating in {Marcia: is this correct?} role-plays and viewing videotapes.

Second Step® has been recognized by several leading institutions as an effective program. It received an "exemplary" rating from the U.S. Department of Education's 2001 Expert Panel on Safe, Disciplined, and Drug-Free Schools. It is included in two searchable online registries: the Substance Abuse and Mental Health Services Administration's *National Registry of Evidence-based Programs and Practice* and the *Model Programs Guide* operated by the U.S. Department of Justice's Office of Juvenile Justice and Delinquency Prevention. Both registries include interventions that have been reviewed and rated by independent reviewers.

REVIEW OF PREVIOUS RESEARCH

Over more than a dozen years, numerous evaluations have been conducted on Second Step®. Studies have generally shown significant improvements in prosocial behaviors, which in other studies have been associated with reductions in student aggression (e.g., Edwards et al., 2005; Cooke et al., 2007).

In the first randomized trial of Second Step®, Grossman and colleagues (1997) used six pairs of matched schools involving the second and third grade classrooms of 12 elementary schools. Participating schools were matched by school district, the percentage of students receiving free or reduced-cost school lunches, and the proportion of minority students. After matching, schools in each pair were randomly assigned to control or treatment groups. There were 418 intervention students and 372 control students. In the intervention group, 56.2 percent were male, 17.7 percent had prior behavioral problems, 23.1 percent were in special education, 86.4 percent lived in two-parent households, and 78.5 percent were white. In the control group, 50.8 were percent male, 22.5 percent had prior behavioral problems, 30.3 percent were in special education, 83.6 percent lived in two-parent households, and 80.1 percent were white.

At the beginning of the study, intervention and control students were similar in levels of social competency and aggressive behavior as reported by teachers and parents. Outcome data was collected at three periods: before the start of the curriculum, two weeks following the conclusion of the program, and at follow-up six months after program completion. Data was collected through teacher and parent ratings.

The study found that immediately following program completion, physically aggressive behavior decreased significantly while neutral/prosocial behavior increased significantly among children receiving the curriculum, compared with children in the control group. These results, however, primarily reflect differences observed on the playground and in the cafeteria (where social encounters are far more frequent) rather than in the classroom. In addition, these behavioral changes were not detected by parent and teacher reports. Finally, while some effects persisted at the six-month follow-up, most of the significant differences between the intervention and control groups dissipated because of a decline in negative behavior in the control group.

A second study by McMahon and others (2000) replicated the findings of the Grossman study with a low-income/high-risk, urban preschool and kindergarten population. This evaluation was similar to its predecessor but did not use a comparison group. The McMahon study found that both preschool and kindergarten children demonstrated significant gains in knowledge, based on interview scores, and significant decreases in problem behaviors, based on behavioral observations. Teacher ratings of children's behavior, however, did not change significantly.

A more recent evaluation of the Second Step® curriculum involved 15 elementary schools (seven schools of kindergarten through fifth grade and eight schools of K–sixth grade) from three cities in western Washington (Frey et al., 2005). Eleven of the schools were randomly assigned: seven to an intervention and four to a control group. The four other schools were assigned to the control group. Schools in the intervention group and control groups did not differ with respect to racial/ethnic makeup or percentage of students receiving free and reduced lunch. The sample, which included a treatment group (N= 620) and a control group (N=615), involved 63 percent of the students in the 15 schools. Participants were ages 7–11 and were roughly divided by gender (48.2 percent were female) and grade level, with equivalent proportions in the two groups. Students were assessed through teacher ratings and self-reports; they also were observed in two conflict situations.

Frey and colleagues found that, when compared with children in the control group, those who participated in Second Step® demonstrated significantly better outcomes in student behavior, prosocial goals, and social reasoning for the whole sample and for the smaller randomly assigned sample. Specifically, children in the intervention group required less adult intervention in minor conflicts, and displayed less aggressive and (among girls) more cooperative behavior while negotiating than those in the control group. Intervention children were also more likely to prefer prosocial goals and give egalitarian reasons for satisfaction than control children. In addition, the findings showed some convergence between teacher-reported and directly observed behavior. Teachers in the first year of the program reported clear increases in social competencies and decreases in antisocial behavior relative to the control group. However, these improvements were marginal in the second year of the program. It was unclear whether the increased rate of social development occurred only in the first year or whether the teachers failed to notice continued improvement.

The Cooke and colleagues study (2007) looked at the implementation of Second Step® in five of the eight participating elementary schools in Meriden, Conn. The third and fourth graders participating in the evaluation (N=741) were 39 percent Hispanic, 47 percent white, 13.5 percent African American/Black, and 0.7 percent other races/ethnicities. Almost half (47 percent) came from low-income households. There was no control group available, because implementation of Second Step® was mandated citywide. The evaluation included a student self-report questionnaire, a student behavior observation checklist used by trained research assistants, and a disciplinary referral checklist that coded disciplinary referral records for the year of program implementation and the preceding year. The findings were consistent with other findings. Students showed significant improvement in positive approach/coping, caring/cooperative behavior, suppression of aggression, and consideration of others. There was no significant change in fighting behavior, and there were small but significant increases in angry and aggressive behaviors during the school year. One in four students showed positive changes on self-report measures of prosocial behaviors.

IMPLEMENTATION STATUS

Schools

DCPS Educational Centers were selected for Second Step® because of the grade range between prekindergarten and eighth grades. Within the first three to four months following the staff

development sessions held in August and September, 12 of the 16 participating schools have two or more teachers implementing the Second Step® curriculum. The 16 schools are

1. Brightwood Educational Center
2. Browne Educational Center
3. Burroughs Educational Center (PK–8)
4. Emery Educational Center
5. Francis–Stevens Educational Center
6. Langdon Educational Center
7. LaSalle–Backus Educational Center
8. Marshall Educational Center
9. Noyes Educational Center
10. Raymond Educational Center
11. Shaed Educational Center
12. Takoma Education Center (PK–8)
13. Truesdell Educational Center
14. Walker–Jones/R.H. Terrell Educational Center
15. West Educational Center
16. Whittier Educational Center

Second Step® Staff and Training

ICSIC has chosen to implement the Second Step® curriculum in K–8 elementary schools in prekindergarten through eighth grade classrooms. The Second Step® curriculum is taught by classroom teachers who are trained to teach the lessons and give positive reinforcement through their interactions with students. During this initial year, 104 staff attended the two-day training sessions. Onsite follow-up is being provided early throughout the year.

Principals were asked to identify one or two teachers in each grade level who would offer the Second Step® program in their classrooms. A master trainer provided a series of two-day staff development sessions for teachers from elementary schools. Principals from the elementary schools were encouraged to send one or two teachers per grade level. Teachers were paid for their time. One Second Step®: A Violence Prevention Curriculum kit was supplied for every two teachers. Teachers signed out the kit before taking it at the end of the staff development session.

Sixteen elementary schools sent teachers to the training.[a] Eight of the 16 schools sent a team of teachers that included one or more teachers from all or most of the grades. Among the school staff receiving training were grade-level teachers and "other" staff (e.g., counselors, art teachers), for a total of 125 teachers and staff.

Six staff training sessions were conducted. Three were held on weekends over the summer (Aug. 4–5, 6–7, and 12–13). Two were held in the fall (Sept. 13–14 and 15–16), and a third was held Dec. 11–12. A certified Second Step® trainer, Brenda McGuire, conducted the trainings.

Because the classroom teacher delivers the Second Step® curriculum, a strong teacher support program is essential to successful implementation. A two-day staff development program is

[a] This school total does not include the Dec. 11–12 training.

augmented with periodic onsite technical assistance provided to teachers. ICSIC has chosen to use a model that includes an intensive, multiday training session followed by optional periodic onsite technical assistance. The onsite assistance is tailored to the individual needs of schools and teachers. It includes demonstration of lessons by the trainer, consultation regarding delivery of lessons or specific group management concerns, and observation of lessons taught by the classroom teacher. The first follow-up session included visits to 24 classrooms at four schools. During the visits, the trainer consulted with teachers, taught demonstration lessons in the classes, and met with an interdisciplinary team of school staff (teachers, a social worker, a coach, and a school psychologist) to discuss appropriate management strategies for a child demonstrating disruptive behaviors.

Teachers find the curriculum practical and on point. They also find the students can relate to the material.

Many of the teachers trained have begun teaching Second Step® in their classrooms. While some of the teachers with whom the trainer met had not yet begun teaching Second Step®, many said the onsite visit provided them with the assistance they needed to begin teaching the lessons. The trainer reported confidence that these teachers would begin teaching Second Step® in the near future.

Activities to Date

At this early stage of implementation (three to four months after initial training), it is estimated that 2,000 children are in classrooms where the Second Step® curriculum is being taught. In the 16 schools with trained teachers, the portion of students affected by the curriculum ranges from 9 percent to 90 percent of the total enrollment, with an average of 47 percent of students in classrooms where the Second Step® curriculum is being taught. It is expected that, as a greater knowledge base regarding the program develops at these schools and at others, more teachers will have the support needed to use the curriculum with their classes.

LifeSkills® Substance Abuse Training

LifeSkills® Training is a classroom-based tobacco, alcohol, and other drug abuse prevention program for upper elementary and junior high school students. The program has been shown to work in many diverse populations.

PROGRAM OVERVIEW

LifeSkills® Training (LST) is a classroom-based tobacco, alcohol, and other drug abuse prevention program for upper elementary, junior high school, and high school students. LST targets individuals who have not yet initiated substance use. The program is designed to prevent the early stages of substance use by influencing risk factors associated with substance abuse, particularly occasional or experimental use. The LST approach is based on the latest evidence, which indicates the effectiveness of teaching general personal and social skills in combination with drug resistance skills and normative education.

The LST curriculum

- Promotes skills necessary to resist social pressures to drink alcohol, smoke cigarettes, and use drugs
- Helps youth develop greater self-esteem, self-mastery, and self-confidence
- Increases knowledge of the immediate consequences of substance abuse
- Provides students with tools to cope effectively with social anxiety
- Enhances cognitive and behavioral competencies to prevent and reduce a variety of health risk behaviors

The curriculum is designed to be taught in a sequence over three years. During the first, more intensive year, 15 class meetings are held. During the following two years, a refresher and review curriculum is taught. An LST program for parents is also available. The specific program activities are based on cognitive-behavioral learning principles, including role-playing, modeling, immediate feedback, and reinforcement of positive behaviors. Students are encouraged to practice the lessons of the day through homework assignments.

The target population includes children ages 8 to 18 in third through twelfth grades. The intervention has been shown to work with urban, suburban, and rural populations. It has been used successfully with Hispanic, Asian/Pacific Islander, white, and African-American populations.

LifeSkills® Training is widely regarded as an effective prevention approach. It is among the most extensively researched prevention programs in the country. It has been recognized by the National Institute on Drug Abuse, the White House Office of National Drug Control Policy, the U.S Department of Education, the American Medical Association, the American Psychological Association, the National Centers for Disease Control, the Center for Substance Abuse Prevention, and Drug Strategies, Inc. It is highlighted by the *National Registry of Evidence-based Programs and Practice*, a searchable online registry operated by the Substance Abuse and Mental Health Services Administration, and the *Model Programs Guide*, a searchable online registry operated by the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention. Both registries include interventions that have been reviewed and rated by independent reviewers.

REVIEW OF PREVIOUS RESEARCH

LST has been evaluated in a series of studies since 1980. The studies were designed to systematically facilitate LST development and measure the curriculum's effectiveness. The early research examined LST's usefulness as a cigarette-smoking prevention program. Subsequent research has assessed LST's impact as a substance use prevention program and its impact on other risk behaviors, such as HIV risk behaviors, youth violence and delinquency, and risky driving.

A randomized block design was used in 56 schools in New York State to compare the effectiveness of two treatment conditions and a control condition on cigarette smoking, marijuana use, and immoderate alcohol use. Significant effects were found for students (N=3,684) who completed at least 60 percent of the prevention program (Botvin et al., 1990). To

determine whether this program was effective for youth at high risk of substance use initiation, a randomized, controlled prevention trial was carried out at 29 innercity middle schools. Compared with youth (n=332) who did not receive the prevention program, youth in the program (n=426) reported less smoking, drinking, inhalant use, and polydrug use at a one-year follow-up (Griffin et al., 2003).

To test the effect of LST on frequency of alcohol use, episodes of drunkenness, and heavy drinking, comparable New York City schools were randomly assigned to one of two experimental groups or a control condition. Program participants received information regarding consequences of alcohol use and were taught refusal skills. Compared with students in the control group, students who received one of the prevention programs drank alcohol less often, were drunk less often, consumed less alcohol per drinking occasion, and had lower intentions to drink beer or wine and other liquor in the future (Botvin, Schinke, Epstein, Diaz, and Botvin, 1995).

In a study to determine the long-term effectiveness of LST on preventing tobacco, alcohol, and other drug use in junior high school students, 56 middle schools representing nearly 6,000 students were randomly assigned to prevention or a control condition. Students received the program in the seventh grade with booster sessions in the eighth and ninth grades. Follow-up data was collected at the end of their 12th grade year. Classroom teachers who were specially trained taught the program. Outcome evaluations of LST showed significantly lower smoking, alcohol, and marijuana use six years after initial baseline assessment. Prevalence of use of these substances was 44 percent lower for those receiving LST than for the control students. Regular (weekly) use of multiple drugs was 66 percent lower for those receiving the program (Botvin, Baker, Dusenbury, Botvin, and Diaz, 1995).

Recent research has demonstrated the effectiveness of LST for elementary school and middle school students. In a randomized block design, the prevention program was taught in grades 3 through 6. Individual-level analyses showed less smoking in the previous 12-month period, higher antidrinking attitudes, increased substance use knowledge and skills-related knowledge, and lower normative expectations for smoking and alcohol use for those students who received the prevention program. At the school level, annual prevalence for smoking was 61 percent lower for treatment schools and 25 percent lower for alcohol use (Botvin et al., 2003).

The LST program has been extensively evaluated in more than a dozen federally funded studies and has been tested and proven effective among white, African-American, and Hispanic adolescents from a variety of socioeconomic backgrounds in rural, suburban, and urban settings. The program was found effective when implemented under different scheduling formats, with different levels of project staff involvement, and whether the program providers are adults or peer leaders. Stronger prevention effects were found for students in the high-implementation fidelity group—that is, students who received 60 percent or more of the 30 lessons over the three-year span.

ICSIC has primarily targeted the middle school program for implementation of the LifeSkills® program.

IMPLEMENTATION STATUS

Schools

Teachers from the following 30 middle schools and educational centers attended LifeSkills® Training, and many are implementing the program in their health classes:

1. Brightwood Educational Center
2. Browne Educational Center
3. Burroughs Educational Center
4. Deal Middle School
5. Eliot–Hine Middle School
6. Emery Educational Center
7. Francis–Stevens Educational Center
8. Hardy Middle School
9. Hart Middle School
10. Jefferson Middle School
11. Johnson Middle School
12. Kelly Miller Middle School
13. Kramer Middle School
14. Langdon Educational Center
15. LaSalle–Backus Educational Center
16. Lincoln Middle School
17. MacFarland Middle School
18. Marshall Educational Center
19. Noyes Educational Center
20. Oyster–Adams Bilingual School
21. Raymond Educational Center
22. Shaed Educational Center
23. Shaw at Garnet–Patterson Middle School
24. Sousa Middle School
25. Stuart–Hobson Middle School
26. Takoma Educational Center
27. Walker–Jones/R.H. Terrell Educational Center
28. Webb/Wheatley Elementary School
29. West Educational Center
30. Whittier Educational Center

LifeSkills® Training Staff

ICSIC is primarily implementing the LST curriculum as a middle school (grades 6, 7, and 8) initiative. The Physical Education/Health Educators have been selected for LST training so that it can be presented in their units. Currently, it is offered in selected middle and K–8 schools. Once again, program staff are supported by an intensive two-day training session followed by booster sessions provided after the program has been taught for several months.

All middle schools were invited to send staff for training in LifeSkills®; all middle schools, and some elementary and high schools, will implement the program.

Staff Training
Three two-day LST trainings for teachers were provided in August, September, and November. The following topics were covered during the first day of the training:

- Theoretical foundations of the program
- Instructional methods
- Overview of the curriculum
- Maintaining fidelity to the curriculum
- Exercises for practicing

During the second day, participants engaged in "teach back" in small group sessions, during which they practiced teaching lessons and discussed the curriculum's more sensitive topics.

Activities to Date
The American Lung Association (ALA) and the Office of the Deputy Mayor for Education are collaborating to provide LST in DCPS schools. The intention is to implement LST in all middle schools. Five high schools and some elementary schools were also invited to the training and some took part. However, beginning in January 2009, the rollout will be to all middle schools. The curriculum will be inserted into the alcohol, tobacco, and substance abuse section of the health curriculum and will align with the state health curriculum standards set forth by the Office of the State Superintendent of Education.

School Resource Officer Program

School Resource Officers are MPD officers who provide a specialized form of community policing. They provide law enforcement, mentoring/counseling, and education services to a school's students.

PROGRAM OVERVIEW
A School Resource Officer (SRO) is a law enforcement officer who has been specially trained to apply the philosophy, principles, and practices of community policing to schools. He or she has three interrelated goals: 1) prevent juvenile delinquency and crime, 2) promote a positive school climate, and 3) help youth develop the attitudes and life skills they need to become law-abiding, contributing members of their community. Part Q of Title I of the Omnibus Crime Control and Safe Streets Act of 1968, as amended, defines a School Resource Officer as "a career law enforcement officer, with sworn duty, deployed in community-oriented policing, and assigned by the employing police department or agency to work in collaboration with school and community-based organizations" (Girouard, 2001, 1).

The basic SRO model organizes an SRO's duties into three categories or functions: 1) law enforcement, 2) mentoring/counseling, and 3) education (Center for the Prevention of School Violence, 6). SRO training programs are designed to equip law enforcement officers with the skills and knowledge needed to perform these three functions in school settings, although the emphasis can vary considerably from program to program (Finn and McDevitt, 2005, 43).

As summarized below, the ICSIC-selected SRO training, advanced training, and follow-on training prepares SROs in District schools to perform many duties related to law enforcement, mentoring/counseling, and education.

Law enforcement duties include activities such as preventing crime and enforcing the law in partnership with local law enforcement agencies, conducting school safety audits, using CPTED (Crime Prevention Through Environmental Design) strategies to improve school safety, coordinating the school's emergency preparedness program, and serving as first responder (Shomette, 2008a; Shomette, 2008c).

Mentoring/counseling duties involve serving as a positive role model and resource for the school community (i.e., students, teachers, administrators, and parents). In general, activities include setting a positive example, encouraging and reinforcing positive behavior, reaching out to individuals in times of need, being available to answer questions and listen supportively to concerns, offering appropriate advice and problem-solving assistance, and helping individuals connect with appropriate services (Shomette, 2008a; Shomette, 2008c). SROs can collaborate with and refer to—but do not replace—school counselors, school psychologists, and other mental health professionals.

Education duties entail teaching age-appropriate classes on a wide range of law-related and other topics. These classes are designed to ensure that students are aware of the SRO's roles and responsibilities, have an age-appropriate understanding of the law, and know essential safety practices. Classes are also designed to support healthy development and prevent delinquency by teaching positive attitudes and skills for coping with real-life challenges and problems such as gangs, drugs, and stress (Shomette, 2008b; Shomette, 2008c).

REVIEW OF PREVIOUS RESEARCH

The SRO training program selected for District SROs is not evidence based in the same sense as other ICSIC programs. However, the SRO training program is driven by research-based principles and practices. *Community policing*, which constitutes the foundation of the SRO training program, has been practiced nationwide for decades, and the crime prevention effects of community policing have been extensively studied (e.g., Sherman et al., 1997; Skogan, 1996). *CPTED* is a research-based approach for reducing and preventing crime and fear of crime that entails analyzing the "built environment" (National Crime Prevention Institute, 2008) and appropriately altering aspects of its design. In general, CPTED seeks to 1) "control access by creating both real and perceptual barriers to entry and movement" (for example, by installing fences and gates); 2) "provide opportunities to see and be seen" (for example, by removing window coverings in classrooms, trimming hedges, and training teachers and others to watch for and report unusual behavior); and 3) "define ownership and encourage maintenance of territor[y]" (for example, by celebrating the main school entrance with a large sign, keeping current with all building repairs, and quickly removing graffiti) [Zahm, 2007, 7–9; Shomette, personal communication, Nov. 21, 2008].

CPTED concepts were first systematically described in the1960s and 1970s (Robinson, 2008, 4). Key contributors to the multidisciplinary CPTED field include Jane Jacobs, whose ideas relate to

social control theory; Oscar Newman, known for the concept of "defensible space," which is based on Jacobs's work; and C. Ray Jeffery, who based his work first on B.F. Skinner's behavioral learning theory, and later on a more complex "'integrated systems model' of human behavior" (Robinson, 2008 5, 7). In 1969, "the National Institute of Law Enforcement and Criminal Justice (NILECJ, now the National Institute of Justice) undertook a series of research projects to appraise the relationship between the physical environment and risk for criminal victimization" (Robinson, 2008 5, citing Wallis, 1980, 2). In the 1970s, NILECJ, the former Law Enforcement and Assistance Administration (now the Bureau of Justice Assistance), and the U.S. Department of Housing and Urban Development funded a wide range of projects and studies applying the "defensible space" CPTED model (Robinson, 2008, 9–10). Today, CPTED principles are used worldwide in many different settings (e.g., schools, airports, malls, stores, and banks) [Shomette, 2008a, 20; Shomette, 2008c].

Mentoring has been described as "one of the oldest forms of prevention" (U.S. Department of Justice, 1998), and the benefits of mentoring have been widely studied and documented. Risk and protective factor theory and resilience theory are two frameworks that have been used to explain why effective mentoring is so important to healthy development (see the beginning of chapter 3 for more information on risk/protective factor and resilience theory).

SRO programs have been found to have a positive effect on school climate and the perception of school safety by teachers, students, and parents (White, et al. 2002; School Violence Resource Center, 2001; Eisert, 2005). While there is a lack of hard data on how SRO programs affect delinquency and crime in schools, some effect on delinquency and crime is evident from studies that do exist (SVRC, 2001; Johnson, 1999).

IMPLEMENTATION STATUS

Schools

As of fall 2008[a], SROs are located at all of the following schools (number in parentheses is the number of SROs at the school):

1. Anacostia Senior High School (4)
2. Ballou Senior High School (4)
3. Ballou STAY (High) School (1)
4. Banneker Senior High School (1)
5. Bell High School (4)*
6. Browne Educational Center (1)
7. Cardozo Senior High School (5)
8. Choice Academy Middle School/Senior High School (1)
9. Coolidge Senior High School (4)
10. Deal Middle School (2)
11. Dunbar Senior High School (4)
12. Eastern Senior High School (4)
13. Eliot–Hine Middle School (2)
14. Ellington School of Arts (1)
15. Francis–Stevens Educational Center (1)

[a] According to the MPD, the number of SROs is subject to change.

16. Hamilton Center [Special Education] (1)
17. Hardy Middle School (1)
18. Hart Middle School (3)
19. Jefferson Middle School (2)
20. Johnson Middle School (3)
21. Kelly Miller Middle School (2)
22. Kramer Middle School (2)
23. LaSalle–Backus Education Center (2)
24. Lincoln Middle School (4)*
25. Luke C. Moore Academy Senior High School (1)
26. Marshall Educational Center (1)
27. MacFarland Middle School (2)
28. McKinley Technology High School (2)
29. Phelps Architecture, Construction, and Engineering High School (1)
30. Ronald H. Brown Middle School (2)
31. Roosevelt Senior High School (3)±
32. School Without Walls Senior High School (1)
33. Shaw at Garnet–Patterson Middle School (3)
34. Spingarn Senior High School (3)
35. Spingarn STAY (High) School (1)
36. Sousa Middle School (2)
37. Stuart–Hobson Middle School (1)
38. Takoma Educational Center (1) ±
39. Walker–Jones/R.H. Terrell Educational Center (2)
40. Wilson Senior High School (4)
41. Winston Educational Center (2)
42. Woodson at Fletcher–Johnson Senior High School (4)

*Sharing School Resource Officers
±Sharing School Resource Officers

SRO Staff

No new staff were hired for the SRO program. Instead, 103 officers and school security personnel already assigned to the District of Columbia Public Schools were released to attend a four-day training held Aug. 4–7, Sept. 8–11, Sept. 15–18, and Oct. 6–9. In addition, advanced SRO training was conducted four times in one-day sessions on Oct. 20–23. SROs participated in both trainings.

Staff Training

To implement the SRO training, the Office of the Deputy Mayor for Education worked with MPD to contract with Donald Shomette (Shomette & Associates) to develop and deliver appropriate training to SROs and school personnel during this period. Shomette is a highly experienced law enforcement officer, crime prevention specialist, and SRO with particular expertise in community policing, school crisis management, and SRO programming and training for schools in Virginia, Georgia, and New York State. Shomette developed a core Advanced

SRO Training Curriculum and delivered it to 97 SROs assigned to District of Columbia Public Schools. The three-day curriculum includes the following segments:

1. Law enforcement, school safety, and CPTED
2. Mentoring/counseling
3. Classroom education

Instruction in the philosophy, principles, and practices of community-oriented policing is woven throughout the training. Also discussed in depth is the application of these principles and practices to prevent crime and disorderly conduct by influencing one or more elements of the crime triangle (desire, opportunity, and ability).

The *law enforcement, school safety, and CPTED* segment addresses, among other topics, the history of SRO programs; roles, and duties of SROs; school violence; crisis management; conducting school safety audits; and using CPTED concepts and strategies (for example, the "three 'Ds' (designation, definition, and design) and the four principles of natural surveillance (natural access control, territorial reinforcement, and maintenance) to enhance school safety (Shomette, 2008a, 22–24; Shomette, 2008c).

The *mentoring/counseling* segment presents key concepts and guidelines for mentoring and counseling students. Some of the topics include making appropriate referrals; individuals with disabilities; characteristics of an effective mentoring relationship; good mentoring practices; advice for new mentors; parameters for counseling; and developmental issues of early, middle, and late adolescence (Shomette, 2008a, 11–18; Shomette, 2008c).

The *classroom education* segment provides guidelines for effective teaching and public speaking. For instance, Shomette discusses the different ways individuals learn (visual, auditory, kinesthetic/tactile) so officers are aware of how to plan and teach lessons that will be readily understood by students with different learning styles. He structures the training so he models strategies and activities that officers can use to work effectively with youth. To illustrate how to appeal to students with different learning styles, Shomette incorporates various methods of instruction (visual aids, verbal instruction, group activities) into the training. In addition, officers receive an "SRO Toolbox" consisting of roughly 40 lesson plans on critical topics such as: SRO awareness; understanding the law; pedestrian, bicycle, and school bus safety; Internet safety; drug and gang resistance; driving-under-the-influence prevention; self-esteem; making good decisions; refusal techniques; peer pressure; stress management; bullying prevention; coping with anger, grief, and depression; child abuse; rape; latchkey children; and protecting one's car from theft (Shomette, 2008b).

The training also incorporates a presentation by Aryan Rodriguez (DC Office of Human Rights) on "language access." Rodriguez discusses the laws governing interactions with the District's Limited-English Proficient (LEP) populations, and the rights of LEP individuals. She engages the officers in a dialog about their own experiences working with LEP individuals. She distributes "Know Your Rights!" cards to the officers and concludes her presentation with a live demonstration of using the Language Line, which offers 24/7, real-time, live translation services so that officers can communicate effectively with any LEP individual.

Throughout the SRO training, Shomette emphasizes that he is available to the officers if they have questions regarding particular topics or wish to discuss how to deal with specific challenges.

An additional training was arranged in November 2008 for SRO Supervisors from the Metropolitan Police Department, who requested this training based on their SROs' feedback. Shomette condensed the training from 4 days to 1½ days to better accommodate the SRO Supervisors' schedules.

Activities to Date

Drawing on information received during the SRO training, many officers have asked that school safety audits be conducted so they can improve the safety of their schools. Supervisors have given permission for SROs to participate in the safety audits during school break, granting them release time from the regular street duties to which SROs return when schools are not in session. These audits will be conducted by Shomette and groups of officers during the Christmas week and the week afterward. These audits will provide the officers with more opportunities to receive additional training and practice what they are being taught.

Anecdotal evidence suggests that SROs are already using on the job the skills and knowledge they are learning during training. One SRO invited Shomette to a Youth Advisory Council; another SRO requested that Shomette provide onsite technical assistance at her school in early January; and many SROs have provided positive feedback to Shomette and to their supervisors.

Starting in January 2009, Shomette will work with SROs one-on-one and in small groups to assist them in fully implementing the training they received in 2008. This additional, more personalized training will help the officers take advantage of opportunities in their school environments for applying the principles and practices of effective community policing, and identify and address barriers to effective community policing.

4. Early Results

Introduction

This chapter presents the early results that have been documented for several aspects of the District's efforts to improve interagency collaboration, services integration, and outcomes for the District's children and youth. For example, early results have been documented for the training efforts, using surveys of the participants in the trainings for all evidence-based programs. Early results have also been documented for program implementation, using preliminary program data for DC START. For the process evaluation, focus group data has been gathered from the DC START clinicians and from the School Resource Officers. Finally, interview data is being gathered from school principals, and survey data is being gathered from members of ICSIC.

These early results show the following:

Evaluations of training participants on the evidence-based programs found that 22 trainings were conducted by credentialed, experienced, and highly proficient trainers in their fields. A total of 316 school teachers, police officers, school staff, administrators, and others took part in these training programs. Highlights of these trainings found that

More than 300 school teachers, police officers, school staff, and administrators took part in the 22 trainings conducted by highly experienced and credentialed trainers.

- New staff were thoroughly trained on the DC START model's procedures, assessment instruments, and database. One hundred percent of the DC START staff felt that they were proficiently trained and ready to implement the program. The clinicians' preparatory training was sufficiently thorough to ensure fidelity to the DC START model.

- About 100 School Resource Officers and school security personnel were trained. They reported in the training evaluations that the training made them better prepared to identify safety issues in their schools, were more equipped to keep their schools safe, apply crime prevention through environmental design techniques, conduct safety audits, and be more active with youth as a result of the trainings.

- Teachers and other school personnel who participated in the LifeSkills® Trainings and Second Step® trainings reported the trainings prepared them to implement the programs in their classrooms, responded positively to the role playing scenarios, and said the training taught them skills they could use in the classroom.

A focus group of clinicians who went through a training on the DC START program found high levels of enthusiasm and motivation about the program, very positive responses to the training and the trainers, great enthusiasm about the focus of the program on the "whole" child in the context of the larger community (and not just on a student in a school), and high marks for the

two evidence-based therapies taken by DC START, namely, Cognitive-Behavioral Therapy (CBT) and Child-Centered Play Therapy (CCPT).

Early results on the DC START program indicate that appropriately qualified staff were hired and employed in a timely fashion. Project administrators put in place the salient elements of the DC START model. The project rollout and ongoing technical assistance efforts to prepare schools for making appropriate referrals have been effective. During the first eight months of operations, the pilot project served a client population of 109 children and families with complex service needs that are likely to benefit from the intervention. Outcomes will be available in the next annual report.

Early results on the Second Step® program show that 12 schools have two or more teachers implementing the Second Step® curriculum. At this early stage of implementation, it is estimated that up to 2,000 children are in classrooms where Second Step® is being taught.

Evaluation efforts will be expanded and made more systematic and comprehensive in FY 2009, as described in chapter 5. This more in-depth evaluation will become feasible in FY 2009 since more of the evidence-based programs will have been implemented in more schools, more trainings will have been conducted, and more months of experience can then be documented and assessed.

Training Data

Interagency Collaboration and Services Integration Commission Training Summary

To date, 22 extensive, in-depth trainings, each with multiple sessions, have been provided to school administrators, staff, counselors, teachers, and police officers for the five evidence-based programs that are being implemented under ICSIC sponsorship. These trainings have reached 316 participants (in some cases the participants took part in multiple trainings), with the numbers of participants for each course indicated below:

- DC START, 8
- Primary Project, 33
- LifeSkills®, 47
- Second Step®, 125
- School Resource Officers, 103
- Advanced Course training for School Resource Officers, 97

As discussed in chapter 3, all of these trainings were conducted by credentialed, experienced, and highly proficient trainers in their fields.

The implementation of the evidence-based programs is still in the early stages. Thus, it is important to learn how the early trainings on those programs have been going and to identify changes that should be made to ensure that future trainings benefit from the experiences,

assessments, and recommendations from past trainings. For each of the training efforts, participants were asked to

- Provide basic information about themselves and, sometimes, about their level of experience in their field
- Rate their levels of satisfaction with the training they received
- Provide any additional comments or suggestions they might care to offer

DC START TRAINING FOR SCHOOL-BASED CLINICIANS

Three sessions of the DC START training for school-based clinicians were conducted over two weeks, from Aug. 4 through 15. Instructor Robin Kincaid facilitated the Aug. 4–5 and Aug. 11–12 DC START Practices and Procedures sessions; instructor Jodi Mullen led the Aug. 6–8 session concentrating on CCPT; and instructor Mike Maurer led the Aug. 13–15 session, which focused on CBT.

1. Participant Demographics.

This section presents demographic data for the participants who attended the dc start training sessions and completed evaluation forms to rate their overall satisfaction with the training experience.

Twenty evaluation forms were completed on the training. The forms called for rating key dimensions of trainees' overall level of satisfaction with the DC START training, including the extent to which they felt the training helped improve their skills and strategies.[*]

All of the DC START clinicians who attended the training were female, representing seven schools. **Table 4.1** shows that the majority (70 percent) of participants had between two to seven years of experience as a mental health professional (MHP): 37.5 percent had either two to seven years or four to seven years of MHP experience. One fourth (25 percent) had 10 or more years of MHP experience. Respondents reported less overall experience working as a mental health professional in a school setting: half (50 percent) had one year or less of MHP experience in a school setting, while the other half had two or more years.

Table 4.1. Mental Health Professional Experience for DC START Participants

Experience (in years)	N (%)
Mental Health Professional (MHP) Experience	(N=8)
2–3 years	3 (37.5)
4–7 years	3 (37.5)
10 or more years	2 (25.0)
MHP Experience in School Setting	(N=8)
0–1 years	4 (50.0)
2 or more years	4 (50.0)

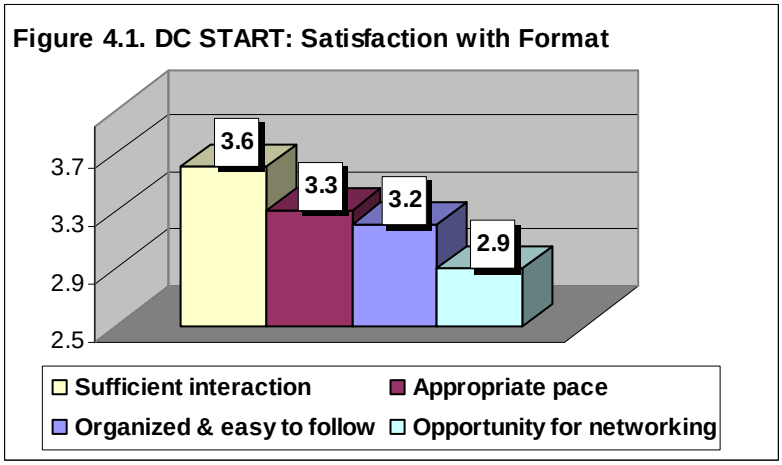
[*]In the case of the DC START training, eight different participants each received up to three different trainings; in total, 20 evaluation forms were completed.

2. Participant Satisfaction.

This section summarizes the results of several questions pertaining to the participants' reported satisfaction levels with the training format, content, and delivery.

Participants were asked to evaluate their overall level of satisfaction with the training format, content, and purpose on a 4-point scale ranging from "Strongly Agree" (4) to "Strongly Disagree" (1).*

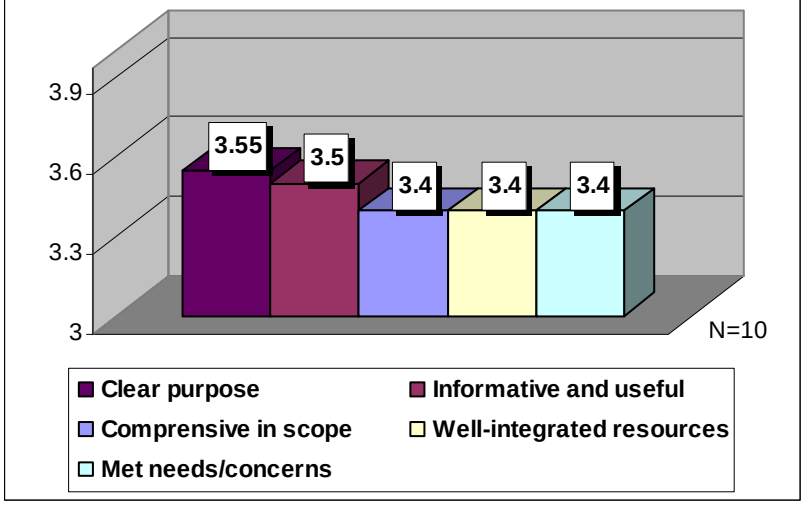
Figure 4.1. DC START: Satisfaction with Format



As shown in **figure 4.1,** respondents were most satisfied with the amount of interaction between participants and presenters, scoring this dimension as a 3.6 on a 4.0 scale. They assigned the lowest score (2.9) to the available opportunity for networking during the training.

Overall, respondents reported positive perceptions of and satisfaction with the training's content. The vast majority (90 percent) of respondents either "Strongly Agreed" or "Agreed" that the training was comprehensive in scope, was informative and useful, provided resources that were well integrated with the content topics, had a clear and easy to understand purpose, and presented content that met their needs or concerns.

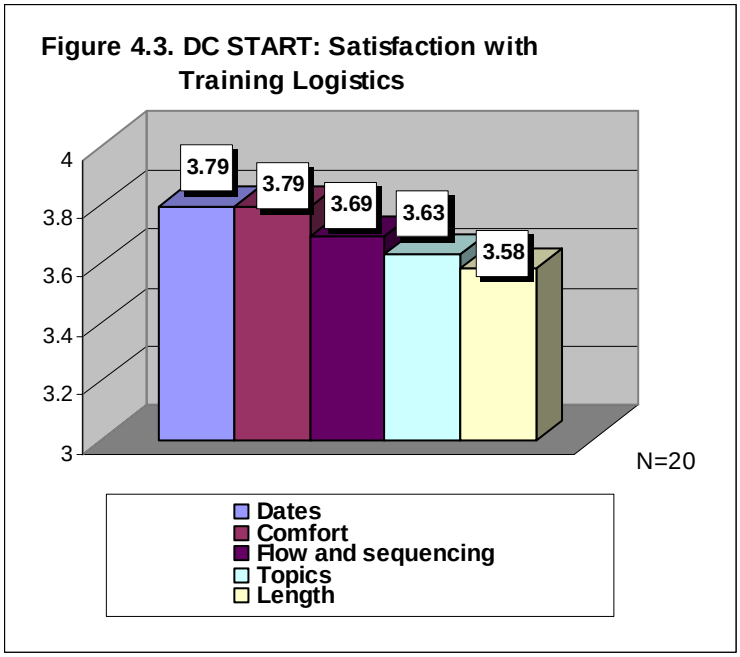
Figure 4.2. DC START: Satisfaction with Content



As shown in **figure 4.2,** respondents scored two aspects of the training content higher than the others: its clear and easy-to-understand purpose (3.55) and its informative and useful content (3.5). Participants rated five dimensions related to training logistics on a 4.0-point scale ranging from "Very Satisfied" (4) to "Not Satisfied" (1). All participants (100 percent) reported being either "Very Satisfied" or "Satisfied" with the training dates, comfort of the environment, training topics, and topic flow and sequencing.

*The results of participant satisfaction summarized in **figures 4.1 and 4.2** are based on the responses captured in 10 evaluation forms collected in the Child-Centered Play Therapy and Cognitive-Behavioral Therapy sessions. Information for the participants in the DC START Practices and Procedures session was not available for all of the questions and was therefore not included in the summary.

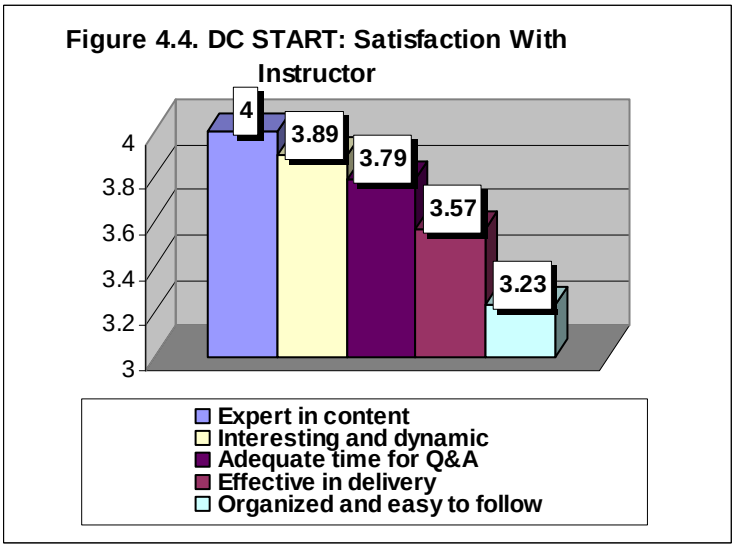
Figure 4.3 shows that, while all five dimensions received high ratings, participants rated two dimensions the highest (3.79): training dates and comfort of the environment.



Overall, DC START training participants rated the effectiveness of the instructors' style and delivery very positively. Responses from participants in the Child-Centered Therapy and Cognitive-Behavioral Therapy sessions showed that 100 percent of the participants either "Strongly Agreed" or "Agreed" that the presenters were experts in the content area; the presenters were interesting and dynamic; and the presenters gave adequate question and answer time.

As indicated in **figure 4.4,** respondents assigned high overall scores to each of the dimensions. Most notably, the respondents assigned the highest possible score (4.00) to their perception of the presenters as experts in content area, followed closely by the presenters being interesting and dynamic (3.89).

One hundred percent of the participants reported that the DC START training prepared them "to a great extent" to use the strategies and skills learned and apply them in their work with children.



Participants were asked to rate the level at which they believe they were in being able to perform a series of tasks at the end of the training on a 4-point scale ranging from "Ready to Implement" (4), "Preparing to Use" (3), "Fully Aware" (2), or "Orienting" (1). The results are presented individually for respondents in each of the three sessions: Child-Centered Play Therapy, Cognitive-Behavioral Therapy, and DC START Practices and Procedures.

Table 4.2 summarizes the results of responses for the 8 participants who completed the CCPT session led by Jodi Mullen. Overall, 100 percent of participants reported feeling proficient ("Preparing to Use" or "Ready to Implement") in five dimensions: orienting the client to the

program, introducing Child-Centered Play Therapy, and highlighting its features and articulating expectations; developing and using an appropriate play environment; acknowledging and demonstrating appreciation of the developmental and socio-cultural perspectives of the child; role-playing to identify feelings and behaviors; and using a range of therapeutic responses and strategies. While participants rated all nine dimensions positively, they rated four dimensions as 3.75 on a 4.00-point scale: orienting the client, introducing CCPT, and explaining expectations; developing and using appropriate play environment; demonstrating appreciation of developmental and socio-cultural perspectives of the child; and role playing to identify feelings and behaviors.

Table 4.2. Reported Level of Proficiency for Child-Centered Play Therapy Session Participants

Questions	Ready to Implement (4) N (%)	Preparing to Use (3) N (%)	Fully Aware (2) N (%)	Orienting (1) N (%)	Average (4-point scale)
Orienting the client to the program, introducing Child-Centered Play Therapy, highlighting its key features, and articulating the expected course of the intervention (N=8)	6 (75.0)	2 (25.0)	0 (0.0)	0 (0.0)	3.75
Facilitating child involvement in CCPT through play and verbalizations (N=8)	5 (62.5)	2 (25.0)	1 (12.5)	0 (0.0)	3.50
Developing and using an appropriate play environment (N=8)	6 (75.0)	2 (25.0)	0 (0.0)	0 (0.0)	3.75
Acknowledging and demonstrating appreciation of the developmental and socio-cultural perspectives of the child (N=8)	3 (75.0)	1 (25.0)	0 (0.0)	0 (0.0)	3.75
Role-playing to identify feelings and behaviors (N=8)	6 (75.0)	2 (25.0)	0 (0.0	0 (0.0)	3.75
Using a range of therapeutic responses to help clients feel understood, become aware of their responsibility in the therapeutic relationship, and gain insight into their behavior (N=8)	3 (37.5)	5 (62.5)	0 (0.0)	0 (0.0)	3.38
Using role-playing and play to improve coping skills (N=8)	6 (75.0)	1 (12.5)	1 (12.5)	0 (0.0)	3.63
Developing outcome indicators for clients with mental health, family, and/or educational problems (N=8)	3 (37.5)	1 (12.5)	4 (50.0)	0 (0.0)	3.25
Encouraging parent/caregiver involvement in the intervention (N=8)	3 (42.9)	1 (14.3)	3 (42.9)	0 (0.0)	3.29

Table 4.3 summarizes the results of seven responses for the four participants who completed evaluations for the DC START Practices and Procedures session led by Instructor Robin Kincaid (a total of five participants completed the training). Participants rated the level at which they believed they were in being able to perform a series of tasks on a 4-point scale ranging from "Ready to Implement" (4), "Preparing to Use" (3), "Fully Aware" (2), or "Orienting" (1). Overall, 100 percent of participants reported feeling very proficient ("Ready to Implement") in six of seven dimensions: training school staff in the use of the observation checklist; determining the extent to which referred students are appropriate for DC START services; obtaining ICSIC consent and waiver forms; developing integrated service plans for clients; administering the Well-Being Assessment Instrument; and selecting the appropriate clinical intervention. Overall, participants who attended the session led by Instructor Robin Kincaid rated all seven dimensions very positively, rating six with the highest possible score (4.0).

Table 4.3. Reported Level of Proficiency for DC START Practices and Procedures Session Participants

Questions	Ready to Implement (4) N (%)	Preparing to Use (3) N (%)	Fully Aware (2) N (%)	Orienting (1) N (%)	Average (4-point scale)
Training school staff in the use of the Observation Checklist (N=4)	4 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	4.00
Determining the extent to which referred students are appropriate for DC START services (N=4)	4 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	4.00
Obtaining consent and waiver using the form developed by the Interagency Collaboration and Services Integration Commission (N=4)	4 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	4.00
Developing integrated service plans for clients and household members to address unmet service needs (N=4)	4 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	4.00
Administering the Well-Being Assessment Instrument (N=4)	4 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	4.00
Using the Children At-Risk Interagency database (N=4)	3 (75.0)	1 (25.0)	0 (0.0)	0 (0.0)	3.75
Selecting the appropriate clinical intervention (N=4)	4 (100.0)	0 (0.0)	0 (0.0)	0 (0.0)	4.00

Table 4.4 summarizes the results of responses for the seven participants who completed the Cognitive-Behavioral Therapy session led by Mike Maurer. Participants rated the level at which they believed they were in being able to perform a series of tasks on a 4-point scale ranging from "Ready to Implement" (4), "Preparing to Use" (3), "Fully Aware" (2), or "Orienting" (1). Overall, 100 percent of participants reported feeling proficient ("Preparing to Use" or "Ready to Implement") in two dimensions: orienting the client to the program and using role-playing to provide an opportunity for the client to practice coping skills and use a problem-solving approach. Over 85 percent of participants reported feeling proficient ("Preparing to Use" or

"Ready to Implement" in three other dimensions: teaching the client to identify self-talk and to recognize negative behaviors; employing modeling strategies to assist the client to understand the different aspects of the depicted behaviors; and encouraging the parent/caregiver involvement in the intervention. Overall, respondents scored highest (3.71) their proficiency in being able to orient to the program and highlight key intervention activities and expectations.

Table 4.4. Reported Level of Proficiency for Cognitive-Behavioral Therapy Session Participants

Questions	Ready to Implement (4) N (%)	Preparing to Use (3) N (%)	Fully Aware (2) N (%)	Orienting (1) N (%)	Average (4-point scale)
Orienting to the program, highlighting the key activities, and articulating the expected successes of the intervention (N=7)	5 (71.4)	2 (28.6)	0 (0.0)	0 (0.0)	3.71
Using a variety of engagement techniques to facilitate client involvement and verbalizations (N=7)	3 (42.9)	2 (28.6)	2 (28.6)	0 (0.0)	3.14
Teaching the client to identify self-talk and feeling and to recognize negative behaviors (N=7)	2 (28.6)	4 (57.1)	1 (14.3)	0 (0.0)	3.14
Providing techniques to promote tension release (N=7)	1 (14.3)	3 (42.9)	3 (42.9)	0 (0.0)	2.71
Developing problem-solving skills that assist the client to recognize that his or her problems are manageable and to encourage him or her to focus on and evaluate several solutions (N=7)	2 (28.6)	2 (28.6)	2 (28.6)	1 (14.3)	2.71
Using cognitive restructuring and attribution retraining techniques (N=7)	3 (42.9)	2 (28.6)	1 (14.3)	1 (14.3)	3.00
Employing modeling strategies to assist the client to understand the different aspects of the depicted behavior or behaviors (N=7)	4 (57.1)	2 (28.6)	1 (14.3)	0 (0.0)	3.43
Using role-playing to provide an opportunity for the client to practice coping skills and to use a problem-solving approach to difficult situations (N=7)	3 (42.9)	4 (57.1)	0 (0.0)	0 (0.0)	3.43
Encouraging parent/caregiver involvement in the intervention (N=7)	4 (57.1)	2 (28.6)	1 (14.3)	0 (0.0)	3.43

3. Comments, Suggestions, and Feedback.

This section provides a summary of additional comments, suggestions, and/or feedback shared by training participants. Responses are categorized into major themes and grouped by the frequency of responses (denoted by the number in parentheses), where applicable.

The concluding section of the evaluation asks participants to provide feedback about additional support or follow-up training that the Office of the Deputy Mayor for Education could provide to promote implementation of lessons learned in the DC START training. The most frequently cited request was for ongoing training and education opportunities, including regular booster sessions to reinforce skills. These kinds of trainings began at the start of the program and plans are in place to continue them. The list of comments in their entirety is listed in appendix F.

PRIMARY PROJECT TRAINING

The Primary Project training was conducted over a two-day period on Oct. 6–7, 2008 and December 8–9.* Thirty-three participants who will be employed as Child Associates in 12 schools were trained. Certified trainer Mary Anne Peabody facilitated the sessions.

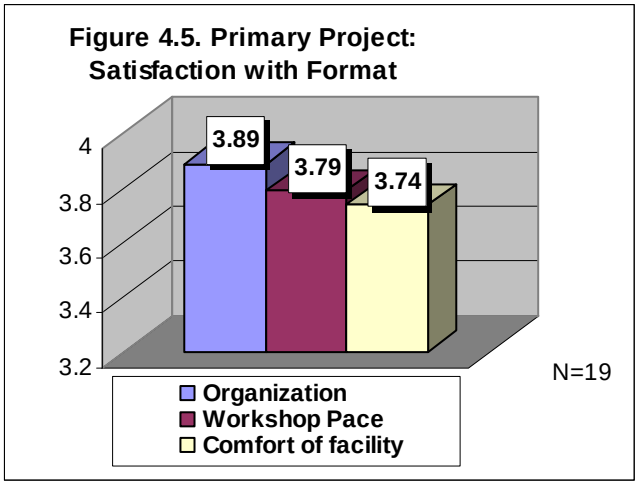
1. Participant Demographics.

This section presents demographic data for the participants who attended the primary project training sessions and completed evaluation forms to rate their overall satisfaction with the training experience.

A total of 19 respondents completed the Oct. 6–7 training and rated their overall satisfaction with their training experience. Nearly all (94.7 percent) of the participants were female and African-American. There was one male in attendance, and one respondent who identified as Latino/Latina.

2. Participant Satisfaction.

This section summarizes the results of several questions pertaining to the participants' reported satisfaction levels with the training format, content, and delivery.



Participants evaluated the training content and effectiveness of the presenter by scoring twelve dimensions related to the training content, format, and facilitator's presentation style on a 4-point scale, ranging from "Excellent" (4) to "Poor" (1). Overall, respondents scored each of the dimensions very highly. All (100 percent) rated 11 aspects of the training as either "Excellent" or "Above Average": organization; usefulness of materials, visual aids, and demonstrations; pace of the workshops; comfort of the facility; and the trainer's knowledge of materials, presentation style, ability to answer questions and relate to the audience, and enthusiasm. The overall results are summarized in **figures 4.5 to 4.7.**

*The summary of participant demographics and reported satisfaction with the training experience is based on the responses of the 19 participants who completed the Oct. 6–7 Primary Project training session.

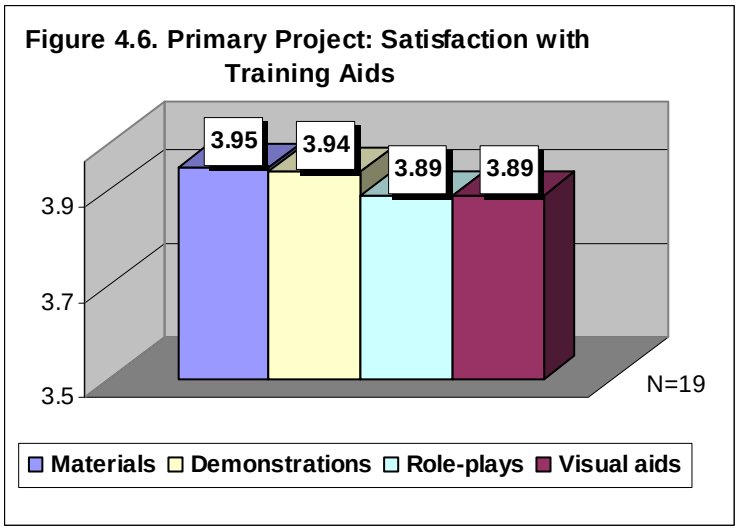
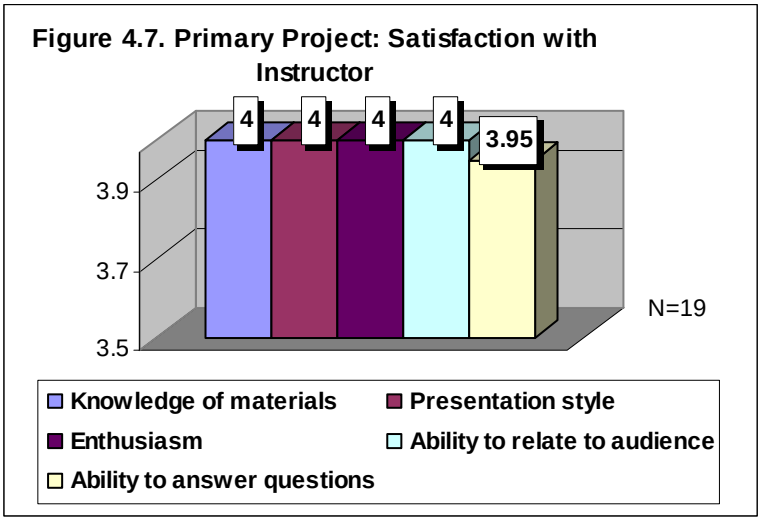


Figure 4.5 shows that the 19 respondents scored highly each aspect of the Primary Project training format. Most notably, the training's organization received an overall score of 3.89 on a 4.00-point scale.

Respondents were deeply satisfied with the content of the Primary Project training and the usefulness of the training aids. As indicated in **figure 4.6,** high overall scores were assigned to each of the categories related to this section.

As illustrated in **Figure 4.7,** participants shared extremely positive feedback about the Primary Project instructor, scoring her effectiveness as a 4 on a 4-point scale in four dimensions: knowledge of materials; presentation style; ability to relate to the audience; and enthusiasm. The trainer's ability to answer questions received a near-perfect score (3.95). Overall, respondents scored the training as a 9.8 on a 10.0-point scale, with 10 being "Great!"

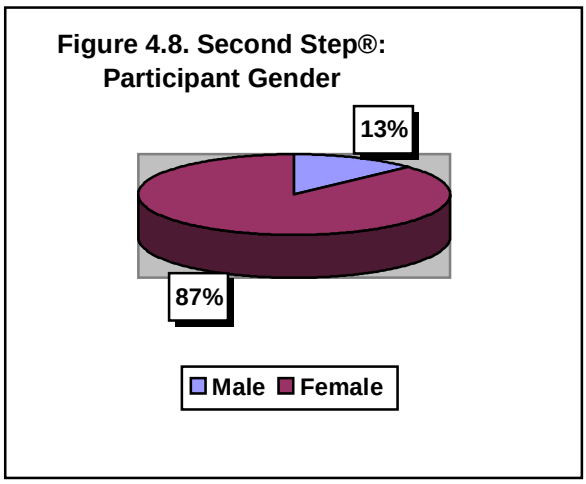


3. Comments, Suggestions, and Feedback.

This section provides a summary of additional comments, suggestions, and/or feedback shared by training participants. Responses are categorized into major themes and grouped by the frequency of responses (denoted by the number in parentheses), where applicable.

Participant responses to the three optional questions add further support to the high overall success rate with the training. Some specific examples of areas that respondents identified as most helpful were the trainer's enthusiasm and willingness to answer questions; visual aides (video and handouts) (2 responses); and the role-playing scenarios involving interaction between the child and the child associate (8 responses). One respondent reported that the role-playing exercises were helpful ways to "step into the role as a child," while another felt that learning the power of play was beneficial. Another participant commented that the most helpful aspect of the workshop was learning other ways to relate to children and their feelings.

The majority of suggestions for future training and/or ways that the current training could be improved related to logistics such as the length of training time. Specific suggestions include abbreviating the length of time into one day or less; providing lunch and/or snacks; and distributing copies of the PowerPoint presentation. The only content-based suggestion made was to focus more on suppression. The following content-based suggestions were made: use of a child in the training; more play therapy for master's level clinicians; additional follow-up trainings. The list of comments, feedback, and suggestions can be found in appendix F.



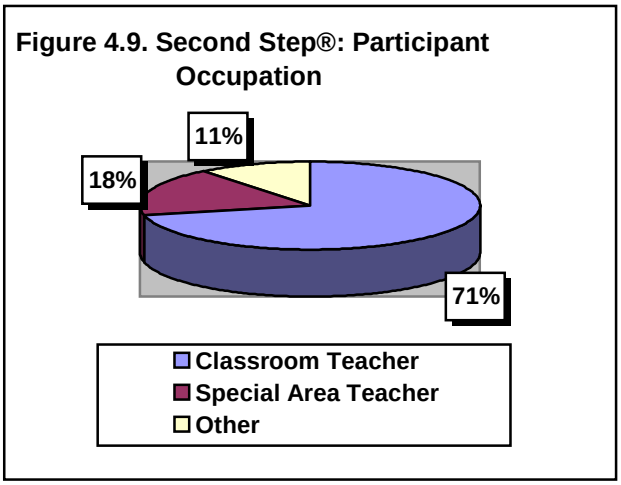
SECOND STEP® VIOLENCE PREVENTION TRAINING

The Second Step® Violence Prevention training workshops were conducted in a two-day format on Aug. 4–5, 6–7, and 12–13, on Sept. 13–14 and 15–16, and on Dec. 11–12. A total of 104 participants representing 16 schools completed the training and rated key dimensions to evaluate their overall level of satisfaction with the Second Step® training experience.

1. Participant Demographics.

This section presents demographic data for the participants who attended the Second Step® training sessions and completed evaluation forms to rate their overall satisfaction with the training experience.

Figure 4.8 shows that the participant group was predominantly female (86.9 percent). Participants were asked to select the category that best described their role within the school: 71.3 percent of participants identified as classroom teachers (**figure 4.9**), while 17.8 percent identified as a special area teacher and 10.9 percent categorized themselves as "other." The occupations of the 11 respondents who identified as "other" include counselor, intervention specialist, psychologist, social worker, literacy professional and staff developers, and numeracy, SAM, and Academic Intervention coaches.



As indicated in **table 4.5,** there was wide variation in the participants' reported teaching experience: 22 (23.9 percent) had 7 years or less of teaching experience; 26 (28.3 percent) had 8 to 15 years; 21 (22.8 percent) had 16 to 24 years; and 23 (25 percent) had 25 or more years of teaching experience at the time of the training.

Table 4.5. Teaching Experience for Second Step® Training Participants	
Teaching Experience	**N (%)**
Years of teaching experience	**(N=92)**
0–7 years	22 (23.9)
8–15 years	26 (28.3)
16–24 years	21 (22.8)
25 or more years	23 (25.0)
Missing	12
Grade taught	**(N=89)**
PS/PK, K, HeadStart, Montessori	21 (23.6)
Grades 1–4	21 (23.6)
Grades 5–8	21 (23.6)
Two or more grades	26 (29.2)
Missing	15
Years of experience at this grade level	**(N=81)**
2 years or less	22 (27.2)
3–6 years	18 (22.2)
7–14 years	22 (27.1)
15 or more years	19 (23.5)
Missing	23

The participants were composed of a diversified group of classroom teachers and personnel from preschool through grade 8 and special programs, including Head Start, ESL, and Montessori programs. Nearly one fourth (23.6 percent) of the respondents taught students in preschool, prekindergarten, Head Start, or Montessori programs; 23.6 percent taught in grades 1 through 4; and 23.6 percent taught in grades 5 through 8. Nearly one third (29.2 percent) reported teaching two or more grades. Slightly more than one fourth (27.2 percent) of participants reported having 2 years or less of teaching experience at their current grade level, about 22 percent had 3 to 6 years, 27 percent had 7 to 14 years, and 23.5 percent had 15 or more years of teaching experience at their current grade level.

2. Participant Satisfaction.

This section summarizes the results of several questions pertaining to the participants' reported satisfaction levels with the training format, content, and delivery.

Overall, the participants who completed and evaluated the Second Step® training reported positive perceptions and high levels of satisfaction with their training experience. The majority (73 percent) of the 103 participants who evaluated their overall training experience rated the Second Step® training as "Excellent" on a 5-point scale ranging from "Excellent" (5) to "Poor" (1). The overall rating for the training was 4.63.

Figure 4.10. Second Step®: Overall Satisfaction

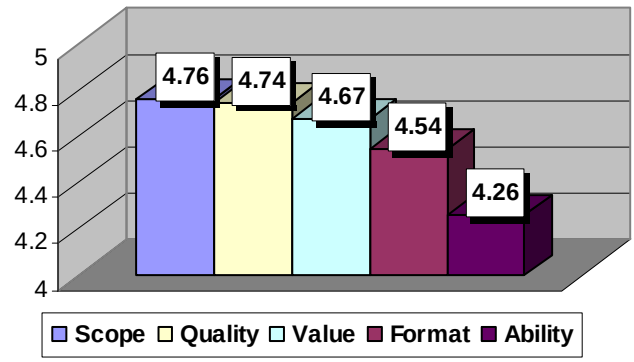


Figure 4.10 shows that, overall, respondents scored highly all five dimensions related to their overall satisfaction with the training on a 5-point scale ranging from "Very Satisfied" (5) to "Very Dissatisfied" (1): scope of the information presented (4.76); quality of the

training (4.74); overall value of the training in understanding the need for violence prevention in their school (4.67); format of the training (4.54); and their ability to effectively integrate the Second Step® program into their current curriculum (4.26). The overwhelming majority of respondents reported being either "Very Satisfied" or "Satisfied" with the scope (99 percent), quality (97 percent), and overall value (98 percent) of the information presented for the Second Step® training.

Participants were asked to respond either affirmatively or negatively to four additional questions to provide feedback regarding their training experience. Overall, the results were very positive. All (100 percent) of the respondents reported that the materials were understandable. The vast majority (about 95 percent) reported that the Second Step® training was effective in providing opportunity for interaction, would recommend the training to others, and felt the program met their expectations.

3. Comments, Suggestions, and Feedback.
This section provides a summary of additional comments, suggestions, and/or feedback shared by training participants. Responses are categorized into major themes and grouped by the frequency of responses (denoted by the number in parentheses), where applicable.

The concluding section of the Second Step® evaluation asks respondents to list two examples of how they can apply what they learned in training in their classroom or school. Respondents cited many thoughtful examples of how they planned to use and apply the Second Step® lessons into their daily routines. Specific aspects of the training that participants identified as being particularly useful tools they could integrate into their classroom or school routine include Second Step® activities including the role-play scenarios (6 responses), the "Fishbowl" (4 responses), "Pair and Share" (2 responses) and "Morning Circle" exercises (2 responses), and the use of puppets and songs to teach the curriculum (6 responses); the use of incentives to reward good behavior; the different "calming methods" taught to help students deal with their anger positively (2 responses); and the use of story cards to begin or end the school day (3 responses). The participants also shared examples of many positive aspects of the training that they are able to apply in their classrooms, including constructive strategies to promote conflict resolution and anger management (32 responses); the use teachable moments to model and reward good behavior (47 responses); effective strategies to reinforce the importance of respect and empathy(47 responses), the value of sharing, and positive self-image (5 responses); methods to educate parents and students about the dangers of drug use and abuse; and engaging peer mediation tactics to improve communication (4 responses).

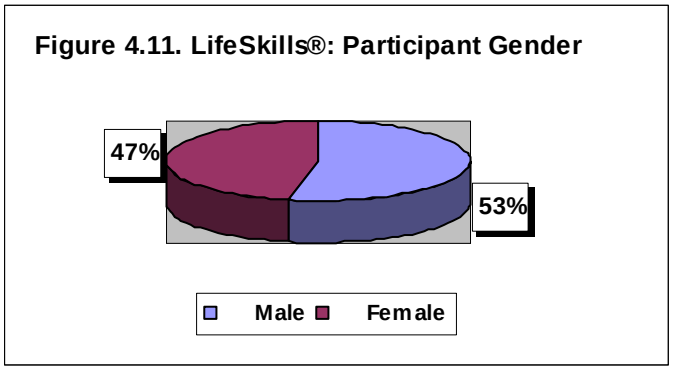
Respondents were also encouraged to provide additional feedback. Overall, feedback about the training format and content was very positive. Several respondents specifically noted they were pleased with the level of class engagement and interaction with the instructor during the session. The list of examples, questions, concerns, and feedback is listed in entirety in appendix F.

LIFESKILLS® TRAINING

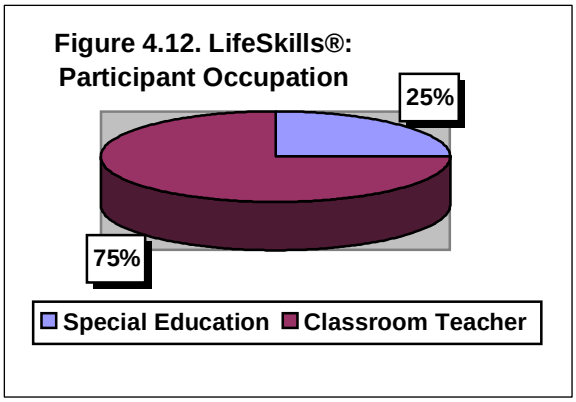
LifeSkills® Training (LST) was conducted in a two-day format on Aug. 14–15, Sept. 11–12, and Nov.19–20, 2008. Separate training sessions were conducted for the LST Middle School and LST High School programs. Approximately 47 participants, most of whom were health education teachers representing 34 schools, completed the training on Aug. 14–15, Sept. 11–12 session, and Nov. 19–20.

1. Participant Demographics.

This section presents demographic data for the participants who attended the Lifeskills® substance abuse prevention training sessions and completed evaluation forms to rate their overall satisfaction with the training experience.



Participants were asked to complete two evaluation forms to rate key dimensions related to their overall satisfaction with the LST training. A total of 32 evaluation forms were collected: 8 Office of the Deputy Mayor's evaluation forms and 24 LifeSkills® Training Workshop evaluation forms. The results are summarized below. **Figure 4.11** shows that the composition of the participant group for whom demographic information was available was about equally divided by gender: 53 percent of the participants were male and 47 percent were female. Seventy-five percent of the participants identified as classroom teachers, and 25 percent worked in special education (**figure 4.12**).*



As indicated in **table 4.6,** the group of respondents was fairly evenly distributed between middle school and high school teachers: 57.1 percent of the participants taught grades 6 to 8, and 42.9 percent taught grades 9 to 12. There was wide variation in the respondents' reported teaching experience: 28.6 percent reported having 0 to 8 years of experience; 42.8 percent had 10 to 19 years; and 28.6 percent had 26 to 40 years of teaching experience at the time of the training. Participants fell into two main categories of teaching experience: just over half (57.2 percent) of participants reported having 8 years or less of teaching experience at their current grade level, while 42.9 percent had 19 to 40 years of experience at the time of the training.

*The gender breakdown summarized in **figure 4.11** was determined by information provided on the LST sign-in sheets and information on the Office of the Deputy Mayor's evaluation form. The results summarized in **figure 4.12, table 4.6,** and **figure 4.13** are based on the responses of the eight participants who completed the Office of the Deputy Mayor's evaluation forms.

2. Participant Satisfaction.
This section summarizes the results of several questions pertaining to the participants' reported satisfaction levels with the training format, content, and delivery.

Table 4.6. Teaching Experience for LifeSkills® Training Participants	
Teaching Experience	**N (%)**
Grade taught	(N=7)
Grades 6–8	4 (57.1)
Grades 9–12	3 (42.9)
Missing	1
Teaching experience (in years)	(N=7)
0–8 years	2 (28.6)
10–19 years	3 (42.8)
26–40 years	2 (28.6)
Missing	1
Teaching experience at current grade level (in years)	(N=7)
0–8 years	4 (57.1)
19–40 years	3 (42.9)
Missing	1

Overall, the respondents who completed the LST training workshops reported positive perceptions and high levels of satisfaction with the LST training workshop: (85.5 percent) of respondents rated the training as "Excellent" on a 5-point scale ranging from "Excellent" (5) to "Poor" (1). Overall, the overall training rating was 4.87. All (100 percent) of the participants indicated that they would recommend the training to others and felt that the program met their expectations.

Figure 4.13 shows that respondents gave high overall scores to all five dimensions related to their overall satisfaction with the training on a 5-point scale ranging from "Very Satisfied" (5) to "Very Dissatisfied" (1): scope of the information presented (4.87); format of the training (4.75); quality of the training (4.75); overall value of the training in understanding the need for substance abuse prevention in their school (4.62); and their ability to effectively integrate the LifeSkills® program into their current curriculum (4.31). All (100 percent) respondents reported that they were either "Very Satisfied" or "Satisfied" in four of five dimensions: scope, format, quality, and the value.

Figure 4.13. LifeSkills®: Overall Satisfaction

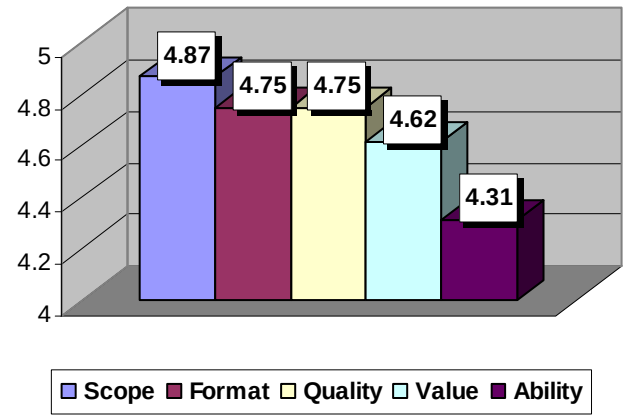


Table 4.7 summarizes the responses of five questions that were asked to measure the participants' perception of how well the LST training workshop satisfied their needs related to

five areas on a 5-point scale ranging from "Exceptionally Well" (5); "Very Well" (4); "Well" (3); "At a Basic Level" (2); to "Not at All" (1). Overall, respondents had a highly positive perception that the LST workshop fulfilled their needs. As detailed in **table 4.7,** 100 percent of respondents felt that the information presented in the training provided the following either "Exceptionally Well" or "Very Well": needed information about LST; an overview and practice of useful teaching techniques; a walk through of the program/curriculum; and an increased understanding of the guidelines for fidelity-based implementation of the LST program. Overall, the respondents felt most positively that the training provided the necessary information about the LST program and gave them an adequate demonstration of the curriculum. Respondents scored most highly their satisfaction with the training's thorough provision of the LST program overview and practice of useful techniques (4.88).

Table 4.7. Overall Satisfaction That Training Met Needs of LifeSkills® Training Participants

Questions	Exceptionally Well (5) N(%)	Very Well (4) N(%)	Well (3) N(%)	To a Limited Extent (2) N(%)	Not at All (1) N(%)	Average (5-point scale)
The information about LST that I needed (N=24)	20 (83.3)	4 (16.7)	0 (0.0)	0 (0.0)	0 (0.0)	4.83
An overview and practice of useful teaching techniques (N=24)	21 (87.5)	3 (12.5)	0 (0.0)	0 (0.0)	0 (0.0)	4.88
A walk-through of the program/curriculum (N=24)	20 (83.3)	4 (16.7))	0 (0.0)	0 (0.0)	0 (0.0)	4.83
Increased my understanding of the guidelines for fidelity-based implementation of the LST program (N=24)	18 (75.0)	6 (25.0)	0 (0.0)	0 (0.0)	0 (0.0)	4.75
Increased confidence in my ability to implement the program (N=24)	17 (70.8)	6 (25.0)	1 (4.2)	0 (0.0)	0 (0.0)	4.67

Table 4.8 summarizes the responses of six questions that were asked to measure the participants' satisfaction with the trainer's performance on a 5-point scale ranging from "Exceptionally Well" (5); "Very Well" (4); "Well" (3); "At a Basic Level" (2); to "Not at All" (1). Overall, the respondents were very satisfied with the quality of the instructor, rating her performance as either "Exceptionally Well" or "Very Well" in four of six dimensions: ability to explain the theory and research of LST; model key skills of Facilitation, Feedback, Coaching, and Behavioral Rehearsal; ability to use or manage training time well; and ability to create comfort and engagement in the training environment. Respondents scored most highly the trainer's ability to use and manage time well and create engagement in the training environment (4.92).

Table 4.8. Overall Satisfaction With Instructor for LifeSkills® Training Participants						
Questions	Exceptionally Well (5) N(%)	Very Well (4) N(%)	Well (3) N(%)	At a Basic Level (2) N(%)	Not at All (1) N(%)	Average (5-point scale)
Explain the theory and research of LST? (N=24)	20 (83.3)	4 (16.7)	0 (0.0)	0 (0.0)	0 (0.0)	4.83
Model key teaching skills of Facilitation and Feedback, Coaching and Behavioral Rehearsal? (N=24)	20 (83.3)	4 (16.7)	0 (0.0)	0 (0.0)	0 (0.0)	4.83
Respond to questions about curriculum and implementation? (N=24)	20 (83.3)	3 (12.5)	1 (4.2)	0 (0.0)	0 (0.0)	4.79
Use or manage training time well? (N=24)	22 (91.7)	2 (8.3)	0 (0.0)	0 (0.0)	0 (0.0)	4.92
Create comfort and engagement in the training environment? (N=24)	22 (91.7)	2 (8.3)	0 (0.0)	0 (0.0)	0 (0.0)	4.92
Reference other NPHA/PHP resources and programs that would support your local initiatives? (N=24)	18 (75.0)	5 (20.8)	1 (4.2)	0 (0.0)	0 (0.0)	4.71

3. Comments, Suggestions, and Feedback.
This section provides a summary of additional comments, suggestions, and/or feedback shared by training participants. Responses are categorized into major themes and grouped by the frequency of responses (denoted by the number in parentheses), where applicable.

The concluding section of the evaluation asked respondents to list two examples of how they can apply what they learned in training in their classroom or school. The most frequently cited response was that participants planned to incorporate the content into their current health or drug and alcohol prevention curriculum; one respondent specifically referenced incorporating the example of the effect of smoking on the heart into the current curriculum. Other ways that participants planned to apply the training content in their classroom/school include as a communication skills training as a teaching method for conflict resolution; use to reinforce skills for "special students;" and incorporate aspects of the violence prevention and social skills information into the current curriculum.

Respondents were also encouraged to provide additional feedback about their training experience. In general, feedback was very positive about the training format and content. Overall, participants felt that the training was valuable in enhancing their skills and were very satisfied with the quality of the instructor. The list of responses can be found in appendix F.

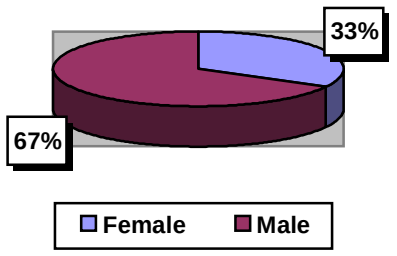
SCHOOL RESOURCE OFFICER TRAINING

School Resource Officer (SRO) trainings were conducted in a four-day session format on Aug. 4–7, Sept. 8–11, Sept. 15–18, and Oct. 6–9. Each session was facilitated by Instructor Don Shomette. A total of 103 participants completed the training and rated key dimensions to evaluate their overall level of satisfaction with the SRO training experience.

1. Participant Demographics.

This section presents demographic data for the participants who attended the School Resource Officer training sessions and completed evaluation forms to rate their overall satisfaction with the training experience.

Figure 4.14. SRO Training: Participant Gender



As shown in **figure 4.14,** the composition of the participant group was primarily male (67 percent). The majority (83.2 percent) of participants were African American.

Just over half (54 percent) of the respondents reported having some college education, while 22 percent completed their associate's degree or higher.

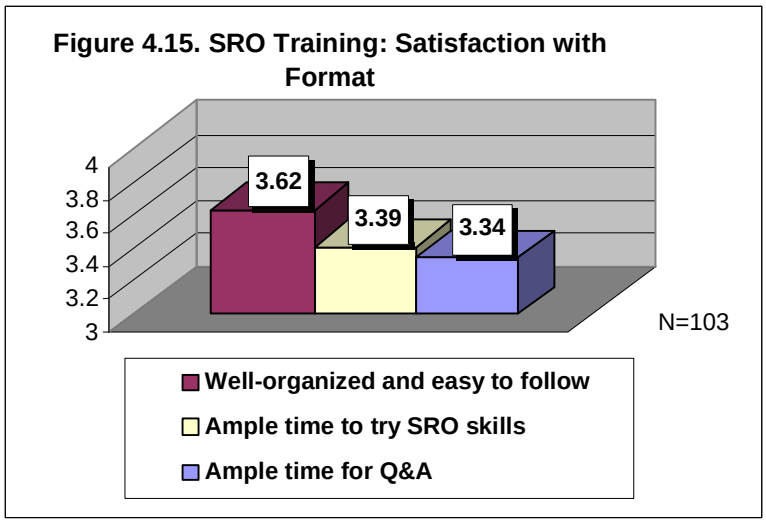
As indicated in **table 4.9,** the majority (67.4 percent) of the participant group had significant experience (5 or more years) as a School Resource Officer. Nearly all (97.9 percent) had 5 or more years of police experience.

Table 4.9. Experience of SRO Training Participants

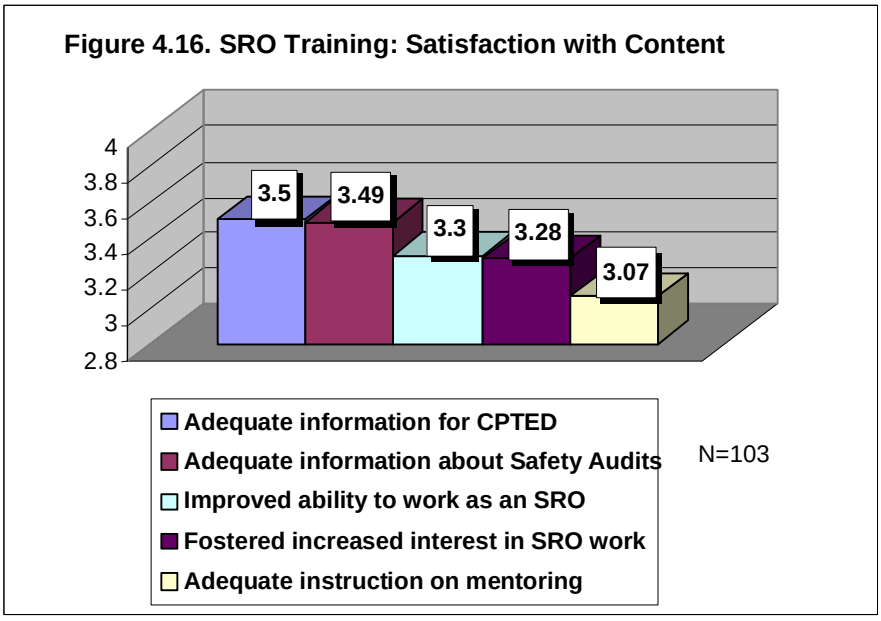
Experience	N (%)
SRO Experience	(N=86)
0–4 years	28 (32.6)
5 or more years	58 (67.4)
Missing	17
Police experience	(N=86)
4 years	2 (2.1)
5 or more years	96 (97.9)
Missing	17

2. Participant Satisfaction.

This section summarizes the results of several questions pertaining to the participants' reported satisfaction levels with the training format, content, and delivery.



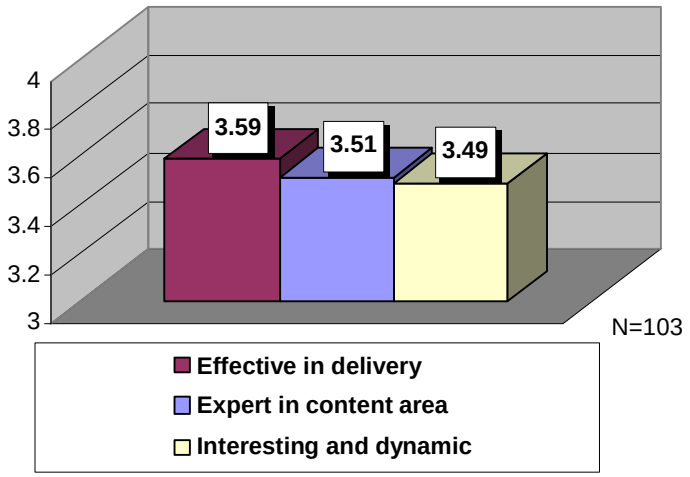
Participants were asked to respond to eleven questions to measure their satisfaction on a 4-point scale ranging from "Strongly Agree" (4) to "Strongly Disagree" (1) with the training content, format, and presenter. The results are summarized in **figures 4.15 to 4.17.** Over 90 percent of respondents either "Strongly Agreed" or "Agreed" that the training format: offered ample opportunity to ask questions about their work as an SRO; was well organized and easy to follow; and provided ample opportunities to practice their SRO skills and techniques. Overall, respondents assigned high scores to each of the three dimensions. Respondents reported being most satisfied with the training format's organization, scoring this category as a 3.62 on a 4-point scale (**figure 4.15**).



There was some variation in the respondents' level of satisfaction with the training content. Over 95 percent of respondents either "Strongly Agreed" or "Agreed" that the training content provided them with the necessary information to implement Crime Prevention Through Environmental Design (CPTED) and conduct safety audits, and over 90 percent felt that the training improved their ability to work effectively as an SRO. Just over 85 percent felt that the training prepared them to mentor at-risk students and increased their interest in serving as an SRO. **Figure 4.16** shows that the participants gave the highest overall score on a 4-point scale (3.5) to the information provided for the CPTED session, followed closely by the information presented in the Safety Audit session (3.49). Respondents gave the lowest score (3.07) to the training's content related to preparing them to mentor at-risk students.

Overall, the respondents reported positive perceptions of and satisfaction with the SRO training, particularly with the training's instructor and format. Over 92 percent of respondents either "Strongly Agreed" or "Agreed" that the trainer a) was an expert in the content areas, b) was effective in delivering information, and c) was interesting and dynamic.

Figure 4.17. SRO Training: Satisfaction with Instructor

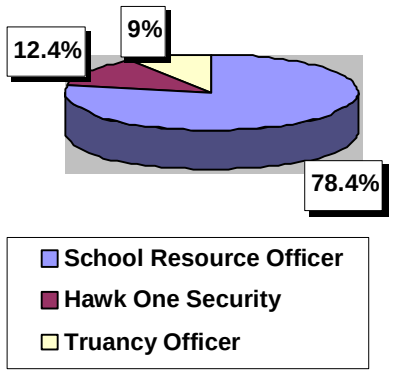


As indicated in **figure 4.17,** respondents scored highly all three dimensions related to the quality of the presenter; most notably, respondents gave the highest score to the presenter's effective delivery style (3.59).

SCHOOL RESOURCE OFFICER ADVANCED COURSE

School Resource Officer Advanced Course trainings were conducted with the Metropolitan Police Department four times in one-day sessions on Oct. 20–23. All three sessions were facilitated by Don Shomette. A total of 97 participants completed the training and evaluated key dimensions regarding their training experience and their overall satisfaction with the course content.

Figure 4.18. SRO Advanced Course: Participant Occupation



1. Participant Demographics.

This section presents demographic data for the participants who attended the School Resource Officer advanced course training sessions and completed evaluation forms to rate their overall satisfaction with the training experience.

Figure 4.18 shows that the majority (78.4 percent) of participants were School Resource Officers. Hawk One Security officers composed about 12 percent of the training group and Truancy officers composed about 9 percent.

Table 4.10 indicates that over half (53.9 percent) of participants had 0 to 7 years of experience in their current position, while 28.6 percent had 8 to 15 years, and 17.6 percent had 15 or more years of experience.

Table 4.10. Experience of SRO Advanced Course Participants

Experience	N (%)
Experience	(N=91)
0–7 years	49(53.9)
8–15 years	26(28.6)
16 or more years	16 (17.6)
Missing	6

2. Participant Satisfaction.

This section summarizes the results of several questions pertaining to the participants' reported satisfaction levels with the training format, content, and delivery.

Figure 4.19. SRO Advanced Course: Overall Satisfaction

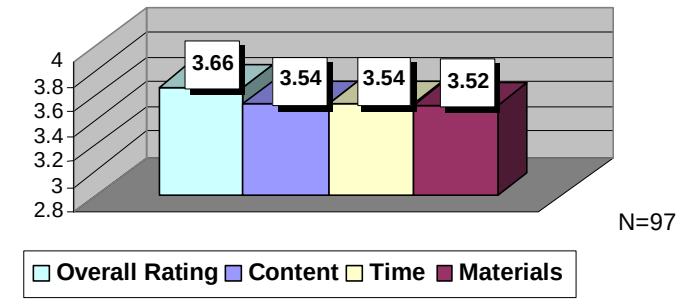
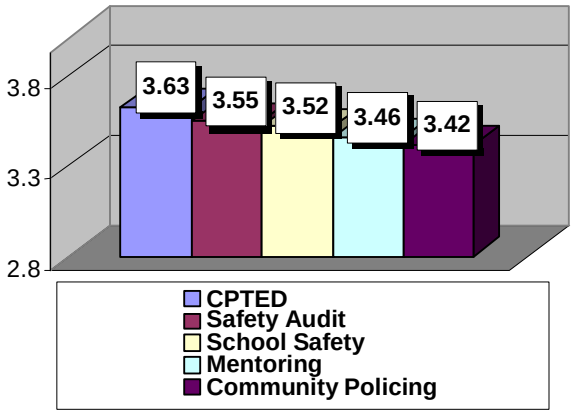


Figure 4.19 summarizes the overall rating of four questions that were asked to measure the participants' satisfaction with the Advanced Course training on a 4-point scale ranging from "Excellent" (4) to "Poor" (1) related to the usefulness and applicability of course content; quality of course materials; the amount of time allocated to cover materials; and the overall course rating. Overall, respondents scored

the course highly on a 4-point scale (3.66). The course content, materials, and presentation time were assigned overall ratings between 3.52 and 3.54. Nearly 95 percent of respondents rated each of these dimensions as either "Excellent" or "Above Average."

Figure 4.20. SRO Advanced Course: Satisfaction With Sessions



Participants rated each session covered in the SRO Advanced Course training. Over 90 percent of respondents or higher rated all five sessions as "Excellent" or "Above Average" on a 4-point scale ranging from "Excellent" (4) to "Poor" (1). **Figure 4.20** shows that the CPTED session received the highest overall rating (3.63), followed closely by the Safety Audit (3.55) and School Safety (3.52) sessions.

3. Comments, Suggestions, and Feedback.

This Section Provides a Summary of Additional Comments, Suggestions, and/or Feedback Shared by Training Participants. Responses Are Categorized Into Major Themes and Grouped by the Frequency of Responses (Denoted by the Number in Parentheses), Where Applicable.

The concluding section of the evaluation asks participants to provide additional feedback about the training and comment on aspects of the training that they most/least enjoyed. Overall, the training received many positive accolades from the group. Fifteen participants specifically praised the instructor, Don Shomette, for his knowledge of the materials and effective delivery. Additionally, eight respondents commented positively about the Safety Audits session, six positively referenced the CPTED content, and 18 shared overall praise about the training. Respondents mentioned several specific aspects of the training that they enjoyed, including games and icebreaker activities; the field trip to Anacostia High School; the SARA plan; and the "Child/Student First" concept. The complete list of comments and feedback can be found in appendix F.

Participants were asked to respond to three open-ended questions to share additional feedback regarding their thoughts about their role as a School Resource Officer and what they planned to do differently after attending the training. The response rate for the additional questions was 82.5 percent (80 out of the 97 total participants).

Respondents provided thoughtful responses as to what they feel they have done right as a School Resource Officer, what they plan to do differently after attending the SRO Advanced Course training, and what they think will make or has made them successful as an SRO. Overall, respondents shared many examples of positive things that they have done during their tenure as an SRO. Common themes include being a positive role model for youth; mentoring and counseling students and families; promoting positive communication with students, parents, school staff, and faculty; enforcing school rules and regulations; exercising patience and listening closely to students and staff needs to establish strong rapport and help with problems;

changing the negative perception that some youth have of police officers; and encouraging youth to attend school.

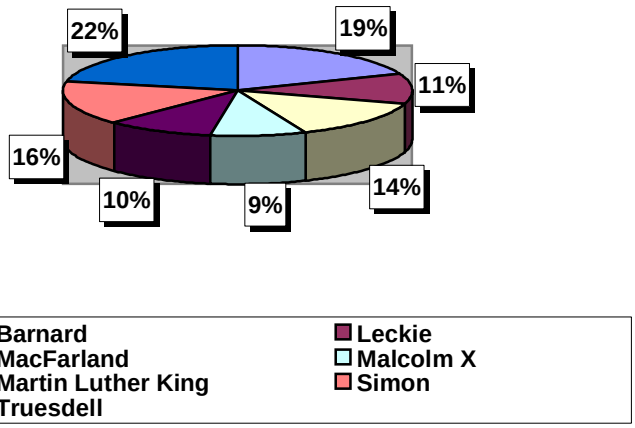
Overall, the most frequently cited responses to what the participants would do differently after attending the SRO Advanced Course training were related to safety and crime prevention. Fifteen respondents noted that they would work harder to identify safety issues at their school, and 14 said that they will look more closely at their school surroundings to determine how they could better prevent crime. Other common responses were improve their security assessment function (2 responses); work with school staff and partners to keep their school safe (4 responses); apply the CPTED and school safety audits in their school (17 responses); conduct more classes to educate students about safety issues (4 responses); be more active with youth and become involved in more programs (2 responses); be overall more observant while on the job (3 responses); implement the material learned in the training; be more self-confident and less judgmental; and focus on quality of life issues (4 responses).

Respondents were also thoughtful in their responses pertaining to what will make them successful as an SRO if they implement it well and consistently. A variety of answers were recorded, with varying themes that included how to better enforce school rules and regulations (4 responses), being more involved with youth and families on a personal level (3 responses), and establishing and maintaining a stronger relationship with school faculty, staff, and administration (4 responses). The responses most frequently cited were to always speak positively to youth (5 responses); to listen more closely to youth's needs and get to know them better (19 responses); to keep an open mind and try to understand or appreciate things from another's perspective (13 responses); to take every threat seriously (2 responses); to establish strong rapport with the school administration, staff, and faculty (14 responses); to be 100 percent committed to their job (2 responses); to make more classroom presentations to educate students about safety issues (3 responses); to always be aware of how youth perceive law enforcement (2 responses); and to be fair, honest, and show that the keeping youth safe is in their best interest (3 responses). The full list of responses can be found in appendix F.

Program Findings

Because this independent evaluation of the ICSIC programs started in September 2008 and the programs are being rolled out in the schools, at the time of this report, DSG can report on only some preliminary findings on DC START. Primary Project child associates will begin taking clients in January 2009, and Second Step® and LifeSkills® teachers are currently in the their first semester of implementation. Future evaluation reports will contain findings on these other programs as well as on DC START.

Figure 4.21. DC START Referrals

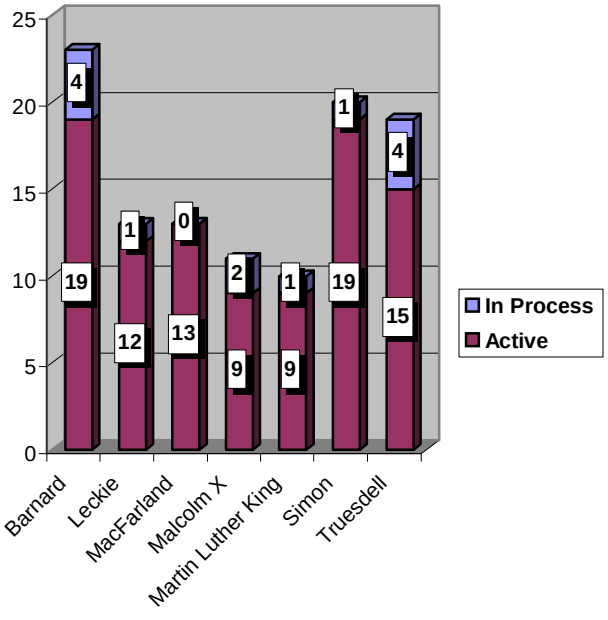


DC START Program Findings

Referrals and Open Cases

The first referrals to the DC START program were made in April 2008 when it began as a pilot project in Barnard Elementary School and Truesdell Educational Center. On August 25, five additional schools—Leckie Elementary School, MacFarland Middle School, Malcolm X Elementary School, Martin Luther King, Jr. Elementary School, and Simon Elementary school—began program implementation.

Figure 4.22. DC START: Cases Open



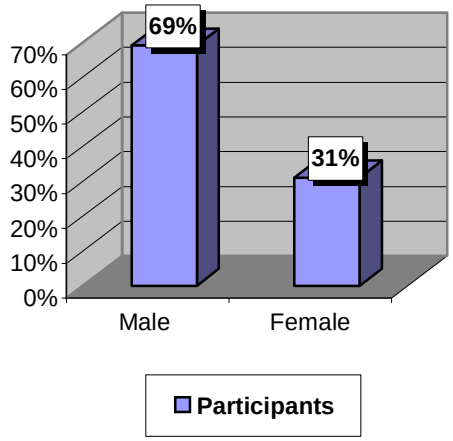
DC START received a total of 186 referrals from April 2008 through Nov. 15, 2008 (see **figure 4.21**). Truesdell referred the largest portion of these youth (22 percent), followed by Barnard (19 percent), and Simon (16 percent). Malcolm X referred the smaller portion of these 186 youth (9 percent).

Of the 186 referrals, there are 109 youth (58.6 percent) open cases in the DC START program. Ninety-six of the 109 cases are currently active (consent and waiver form signed)

while 13 are in process awaiting parental consent. Of the 96 active cases, 100 percent have had at least one Observation Checklist**,** and 76 percent have two or more checklists completed (not shown).

Barnard has the most open cases (23) and Martin Luther King has the fewest (10). (See **figure 4.22**). Malcolm X has the highest rate of successfully enrolling referrals into the program (79 percent). Truesdell, despite the fact that it referred the most youth, has the lowest rate for enrolling those referrals (46 percent, not shown). Common reasons for referrals not resulting in open cases are a) parents not following through with the referral, b) parents refusing treatment, c) student already receiving mental health services, d) student already receiving special education services, and e) student not appropriate for services, therefore a recommendation was made for other services to be put in place instead.

Figure 4.23. DC START: Participant Gender



TARGET POPULATION

Gender

The ratio of boys to girls in the DC START program is 2.20. In other words, for every 1 female involved in the program, there were 2.2 males. Of the 96 active cases, 66 (69 percent) of the DC START participants are male and 30 (31 percent) are female (see **figure 4.23**).

Race

DC START participants were composed of mostly African-American youth. Of the 96 active cases, 84 (88 percent) of the DC START participants are African American, 10 (10 percent) are Hispanic, and 2 (2 percent) are multiethnic (see **figure 4.24**).

Figure 4.24. DC START: Participant Race

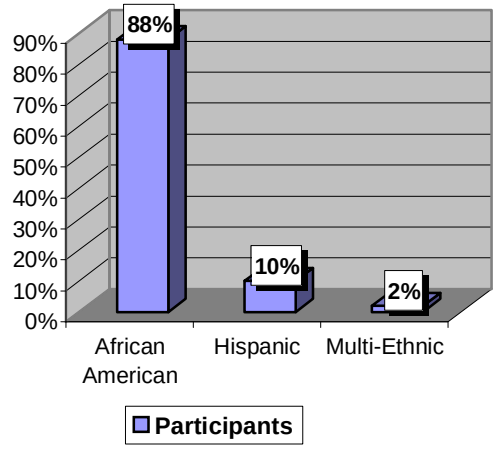
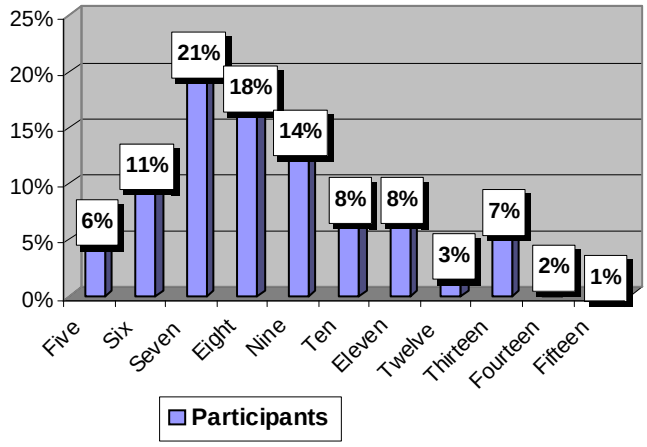


Figure 4.25. DC START: Participant Age



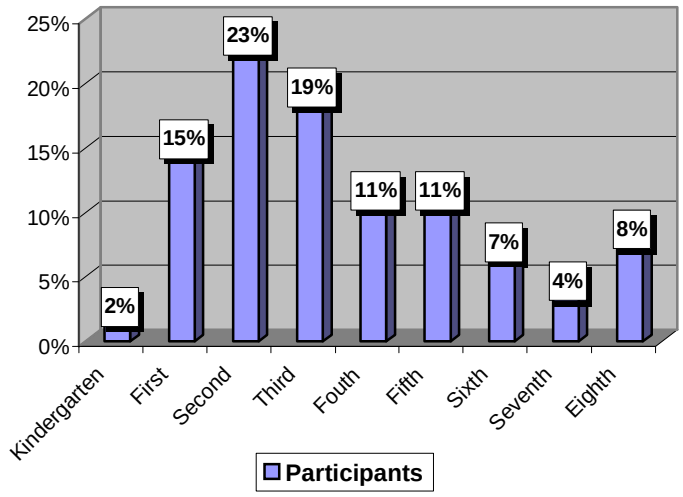
Age

The age of the DC START participants ranged from 5 to 15 years of age. The age category with the largest number of participants (21) was the 7-year-old group, but over half (53 percent) of the participants were between 7 and 9 years of age (see **figure 4.25**).

Grade

Not surprisingly, the grade distribution curve is very similar to the age distribution curve. The grades of DC START participants ranged from kindergarten to eighth grade (see **figure 4.26**). The grade category with the largest number of participants (22) was second, followed by third (18) and first (15). Combined, these three grades comprised over half (57 percent) of the DC START participants. The grades with the fewest participants was kindergarten (2), seventh (7), and eighth (8).*

Figure 4.26. DC START: Participant Grade

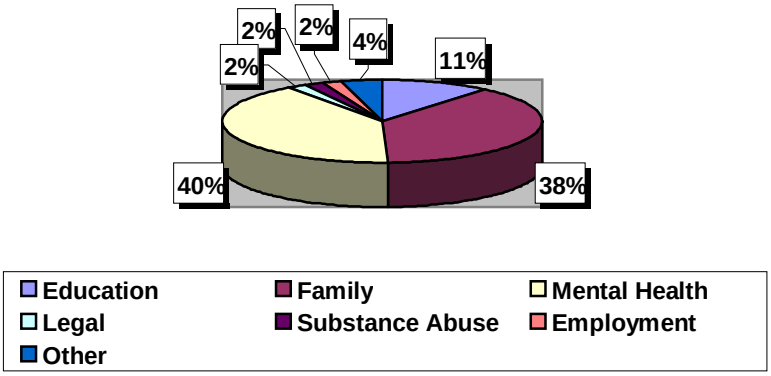


*The pool of schools from which seventh (2 schools) and eighth (1 school) graders are referred is disproportionably small compared with the other grades, resulting in fewer referrals.

TREATMENT PLANS

Of the DC START cases that have been open for more than 45 days, 71 of the 78 cases (91 percent) have treatment plans. Of those treatment plans, 94 percent have three or more goals, for a total of 202 treatment goals. Treatment plans are written in six problem areas: family, education, employment, legal, mental health, alcohol/ substance abuse, and "other." The most frequently cited goals (40 percent) were in the mental health problem area (see **figure 4.27**). Examples of mental health issues reported in the treatment plans are "[the juvenile] suffers from sadness and possibly depression," "displays an extreme amount of aggression," "is often impulsive and unable to control himself," and "refuses to listen and has temper tantrums at least three times a week." Family issues ranked as the second most cited (38 percent) treatment goal. Examples of family issues are "the home life seems chaotic and unstructured," [the juvenile] "has mixed feelings about his relationship with his father and has witnessed numerous trauma throughout his childhood," and "expresses his grief through angry outbursts at school and at home." Legal and employment issues were the least cited (2 percent) of the treatment goals.

Figure 4.27. DC START Treatment Plans



WELL-BEING ASSESSMENT INSTRUMENT

The purpose of the Well-Being Assessment Instrument (Well–BAT) is to identify children who display initial evidence of risk factors associated with mental health, substance abuse, and juvenile delinquency while they are within schools, so services and supports can be provided to them prior to the need for more expensive, intensive services. The Well–BAT is completed by the clinician within 45 days of opening a case and consists of 37 well-being factors divided along three scales: Personal Development; Environmental Influences; and Level of Functioning. Each item is rated on a 0 to 2 scale. Ratings of 0 indicates the clinician believes there is little or no evidence that suggests the student is experiencing (or might experience) problems with respect to the behavior situation assessed by the item or that it is a possible area of strength for the child. Ratings of 1 indicate a moderate level of concern (moderate level) about the student's well-being or adjustment, and ratings of 2 indicate a higher level of concern (high level) about the student's well-being or adjustment.

To date (November 2008), the Well–BAT has been completed on 89 DC START participants. Program participants averaged 4.89 high level risk factors and 9.51 low level risk factors. The results indicate that the most common high-level risk factor among the 89 youth with completed assessment instruments was Temperament (26 youth) and Externalizing Behavior (26 youth). The most frequent high level risk factors identified by clinicians through the Well–BAT are presented below by domain:

Personal Development: Temperament (26); Family History of Substance Abuse (25); Family History of Mental Illness (21); and Family History of Criminal Activity (21); Problem Solving Efficacy (18); Relationship with Peers (17); Social Competence (14); Family Management Style/Expectations (14); and Relationship with Parents (11).

Environmental Issues: Exposure to Violence (24); Stressful Events (23); Stability of Living Arrangement (14); Domestic Violence (13); Types of Peers (12); Family Mobility (12); School Mobility (12); and Parent/Child Discord (12).

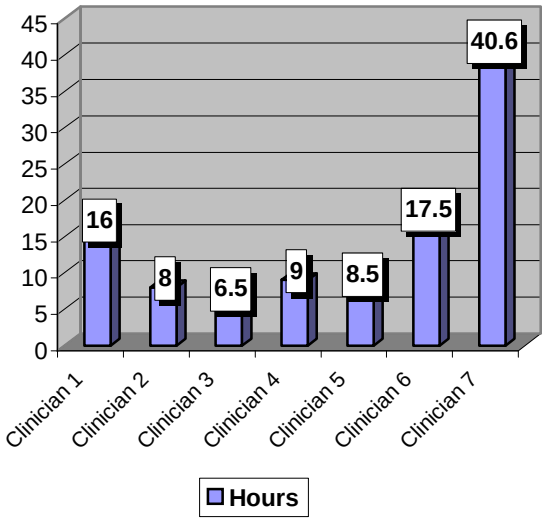
Level of Functioning: Externalizing Behaviors (26) and Internalizing Behaviors (22).

MANAGEMENT INFORMATION SYSTEM

The Children at Risk (CHARI) database is used by the DC START clinicians to record information on a regular basis about their clients. It offers a single point of assessment and accountability for entering information and analyzing results. During the initial months of the program, only one clinician was able to access the system from school (Clinician 7) resulting in significantly more use of the system (see **figure 4.28**). The other clinicians come to the Wilson building once a week and enter data. By July 2009, it is expected that the Office of the Chief Technology Officer will complete an upgrade that will permit clinicians to access the system on the Internet from their school.

Currently, clinicians are expected to spend at least two hours a week entering data on their clients. During the previous one-month period (Oct. 15 to Nov. 15), DC START clinicians spent a total 106.1 hours using the CHARI database. The number of hours using the CHARI database varied significantly by clinician with a maximum of 40.6 (Clinician 7) and a minimum of 6.5 hours (Clinician 3). Overall, the clinicians averaged 15.2 hours each month, but the median (less sensitive to outliers) was 9.0 hours. Six of the seven clinicians averaged two or more hours per week.*

Figure 4.28. DC START Clinician CHARI Hours Per Month



*These numbers should be viewed for informational purposes only. Clinician 3 spent nine hours in the CHARI database the following week to compensate for the infrequent use the previous week. In addition, Clinician 7 occasionally remained logged into the system even when not actively using it. In the near future, the database will be modified to reflect the number of "updates" provided by clinician.

Conclusions

The DC START program is off to an excellent start. The DC START clinicians who have been hired are appropriately qualified and have been thoroughly trained. Three of the seven clinicians have nearly full caseloads after just three months of implementation. The Well–BAT data shows that the program is receiving appropriate referrals of students with multifaceted service needs who are likely to benefit from the intervention.

Future evaluations will present data on the clinical assessment of progress made by clients toward meeting their treatment plan goals, the level of improvement as measured by the Pediatric Symptom Checklist, and changes in school behavior as measured by referrals for school discipline.

Process Evaluation Findings

Focus Group of DC START Clinicians

METHODOLOGY

A focus group of DC START clinicians was conducted in the Wilson Building at 1350 Pennsylvania Avenue NW, on Nov. 26, 2008. The group consisted of the seven clinicians for the DC START programs in the following seven schools: Barnard Elementary School, Leckie Elementary School, Malcolm X Elementary School, Simon Elementary School, Truesdell Educational Center, Martin Luther King, Jr. Elementary School, and MacFarland Middle School. All participants signed and returned consent forms. The interview protocol for the focus group is included in appendix D This focus group, as well as others that are scheduled later for the DC START evaluation, is intended to augment our understanding of the ICSIC programs that are being evaluated and to identify barriers and successes in the implementation process.

The following summaries are based on notes and recordings of the group's discussion.

SUMMARY OF FOCUS GROUP DISCUSSION

1. Being Attracted to and Motivated by the DC START Program

All clinicians expressed a strong interest in and attraction to the DC START program. They mentioned the following aspects of the program that they found to be particularly attractive:

- The DC START program is an early intervention effort.
- The program and key program components are evidence based.
- The program is clearly structured; for example, it includes specific tools for assessments, as part of the curriculum.
- The program encourages flexible interaction with participating students, both at home and at school.
- The program provides for additional outreach in the community, thus allowing for an even fuller understanding of the context for each child as a "whole child," not just as a student.

- The program has allowed focus group participants to feel that they are helping with the "beginning stage to a solution" to some of the problems that have been plaguing District of Columbia schools.

DC START clinicians feel that they are helping with the "beginning stage to a solution" to some of the problems that have been plaguing DC schools.

2. Understanding the DC START Program Model

Participants generally understood that the DC START model is an intervention that targets children who fall in a "grey area"—specifically, children who have some behavior problems, but not such serious behavior problems that require more intensive therapeutic interventions. In that sense, they understood that it is an early intervention program. They also understood that it is an effort to identify children with needs, assess those children and their needs, work with the families of the children, and look at the children in their contexts, not just in treatment settings "as therapists." One participant stated that the program's intent is to help "see the child's whole world," to see "the other side"—and not just see the child as a student who exhibits behavior problems. Teachers don't often see this other, fuller side. Participants also noted that the DC START is a program that has specific tools for assessments, and that it works in unique partnerships with the schools.

3. Getting Trained About the DC START Program

In general, participants said that the experience with the DC START training has been very positive. Participants felt that ongoing trainings had been "great." They liked that they have been provided with excellent resources in the form of journal articles, videos, role-playing, excellent trainers, and excellent training that is, for the most part, hands-on and well structured. Several trainers were singled out as being particularly excellent. Also appreciated was the ongoing ability to consult with the New York program, which one participant said was like having a "big brother" to be able to turn to for help. They noted that the first training focused on the general model, while subsequent trainings focused on the two evidence-based therapies—Child-Centered Play Therapy and Cognitive-Behavioral Therapy—and on the use of the CHARI database. Most participants felt that the CHARI database was the most difficult to master, in part because of technical problems with the system and limited availability of the system.

DC START clinicians found the ongoing training extremely helpful and are enthusiastic about this program as an early intervention.

The training for CCPT was viewed more positively than that for CBT, to some degree. This was due primarily to the nature of the two program approaches: CCPT is clear and structured as a program; CBT is a very broad, more theoretical, and less structured program; and the training reflected these characteristics of the programs themselves.

4. Enrolling Children and Youth Into the DC START Program

According to participants, "the whole school" can refer children into the DC START program, including principals, teachers, counselors, staff, custodians, and others. The Observation Checklist is the tool used for referrals and some clinicians leave copies of the Checklist on their door for this reason. The program is also publicized at back-to-school night, with flyers, and through a newsletter started by program staff. In practice, most referrals come from teachers or from the principal and in all cases an Observation Checklist must be completed by a teacher.

The process of referral and selection to the program entails a number of decisions by clinicians. Clinicians review referrals to determine which are appropriate. If a child already receives counseling/services through an IEP, DC START does not serve them. Again, focus group participants mentioned that the "right" children for the program are those with some (moderate) behavior problems but who have not "crossed the line" to requiring extensive services. It is easier for teachers to see behavior problems that are "externalized," such as acting out, ignoring the teacher, or disruptive behavior. It is harder to notice the "internalized" problems, such as students who are withdrawn. As a result, children with disruptive behaviors are noticed and referred more often. (Participants noted that this tendency should be corrected, over time, as they have more opportunity to work with teachers.) In addition, children are sometimes referred because no other services are available ("they send us everyone") or even because teachers are excited to have the new DC START program available. One participant mentioned that at her school, teachers were "overwhelmed" and so referred more children.

5. Gaining Parental Consent

Participants said they typically go to the family's home to discuss and obtain consent. Parents are almost always interested, but their follow-through is sometimes lacking and some do not show up for scheduled meetings. Gaining consent itself is not difficult, and there are forms available in Amharic, Spanish, Vietnamese, and English.

6. Gathering Information on a Child

Once a home visit is set up and conducted, collecting background information from parents is not difficult because information is compiled through a set of comprehensive tools, including the Well–BAT. As a result, clinicians can try to collect all the information they need in one visit. The PES–Q form is filled out by the children themselves, and their response varies by age. With young children, disclosure (e.g., about drug use) is limited. Self-disclosure is better with middle school children. For children under 11, the Pediatric Checklist is filled out with the parent. Thus, differences in the time needed to complete the information-gathering steps varies, in part because the schools are undergoing changes and the age/grade range at each school is different. The children are sometimes truant, and it takes time to establish the trust necessary for them to reveal the requested information. In general, participants reported that having children complete the forms within 45 days can be difficult, but they expect this to get easier with more experience.

7. Using the CHARI Database for Treatment Planning

Generally, participants felt the CHARI database was very useful. "It really helps a lot in keeping everyone on task." It is a very organized system that helps in assessing progress; the treatment reminders are particularly useful. It is supposed to be updated every 30 days (45 days first time). However, they noted that it takes a long time to master the system, and currently it is necessary to come to an office in the Wilson building to use it. There have also been many technical problems. Until recently, multiple users could not access CHARI at the same time.

8. Implementing Cognitive-Behavioral Therapy

It is somewhat difficult to determine which evidence-based modality to use with enrolled children, and the determination is often accomplished through consultation with the supervisor. Some children don't grasp CBT constructs, and selecting whether to use CBT or CCPT is often based on age—participants typically use CCPT up to third grade and CBT for older children. Still, some older children like the toys used for CCPT. It depends on a child's ability to verbalize (which is necessary for CBT), developmental stage, and presenting issues. And, generally, girls talk more than boys. In middle school, CBT is almost exclusively used—it is "not cool to be playing with toys." Using CBT or CCPT involves a *clinical judgment.*

There is more preparation involved in implementing CBT, because methods for applying/using the concepts have to be developed. Sometimes, if a child comes in with an immediate problem, it is necessary to "shift gears" and adapt the concepts to his or her situation. In addition, some children are not able to write down anything about their personal feelings and emotions. With CCPT, by contrast, it is easier and more concrete—the child comes in and plays, and the interpretation and feedback is based on that. (It was noted that in New York, the preference was toward play therapy.)

9. Implementing Child-Centered Play Therapy

CCPT is an approach to resolving inner issues while playing. Participants seemed very enthusiastic about it, using terms such as "awesome," "easy," and "we love it." There is a considerable amount of therapeutic technique involved, requiring practice, and the ability to be genuine with the child. It is child centered, not based on clinician initiative but what children do with the toys. If a child comes in and throws toys violently or hits the "bop bag," for example, this becomes the impetus for the clinician to work on these issues, to help the child find other ways to express anger and control. But change resulting from CCPT is a more gradual process than it is for CBT.

CCPT empowers children by allowing them a free space to express themselves, where an adult is present who listens to them. It allows the therapist (and the parent) to achieve a new and potentially different view of the child. Said one participant, "If you could see this kid as a child," then you can see the child and not just the "bad student." Positive feedback on the child is often provided to parents and teachers.

10. Getting Support for Dealing With Problems

DC START clinicians have been pleased with the help they have gotten from OCTO on technical problems.

Participants said that they have been able to get help by communicating with the Office of the Chief Technology Officer (OCTO) about technical problems, for example with the CHARI database. There was a lot of this communication in the beginning. The Deputy Mayor's office is very supportive: Supplies and forms are provided when needed. Participants felt that they are "backed up." They have weekly team meetings and individual supervision once a week. Participants felt that there was a sense of "togetherness" among those involved in the program. In addition, the "culture of the office" is one of being connected, by Blackberry and by other means.

However, some clinicians report that support varies from other quarters. There is a considerable amount of change currently occurring as a part of the school restructuring effort. A few principals have not been as supportive of the program as most of the others. Some school staff have taken longer to embrace a program that is not a DC public school program, when so much change is being made within the DC public school system. Sometimes they don't always take such programs seriously. Territoriality, egos, and resentment are factors. However, participants were optimistic, and as a whole felt that, with time and increased rapport, these barriers would change.

Focus Group of School Resource Officers (SROs)

The SROs would like to have a broad role in increasing safety in the schools. They would like to be mentors to help youth, ensure safety, and "teach kids to be respectful and successful." The need to enforce discipline, however, makes carrying out that role difficult.

As discussed in chapter 2 of this report, during summer 2008 the Office of the Deputy Mayor for Education established an interagency working group to ensure that some 20 school consolidations went smoothly and that consolidated schools were prepared to begin the year productively. This working group included representatives from DCPS, MPD (including the Commander of the SROs), Don Shomette (the trainer for the SROs), among others. Meeting weekly throughout the summer, the working group concentrated on developing a comprehensive planning framework and strategies for individual schools to address issues related to student safety, the combining of different populations, school culture, parental involvement, and safe transportation routes. For each school, the working group developed a plan that covered school crossing guard assignments, bus and walking routes, intervention and safety plans for students from rival communities, and engagement activities for students, staff, and parents. Shomette also briefed school administrators on the role of the SROs and the training they received.

METHODOLOGY

A focus group of 12 SROs from middle schools and high schools was held Dec. 8, 2008, at the District 1 Police Station. The District 1 Commander selected the focus group participants. All participants signed and returned consent forms. The purpose of this focus group, and of future focus groups that will be held for the evaluation, is to share experiences and insights about District of Columbia Public Schools, the programs that are being implemented, the progress that is being made, and the issues and barriers that remain to be addressed. This SRO focus group discussed the SRO training that the focus group participants recently received, including what they perceived to be barriers to implementing what the SROs were trained to do. They also offered suggestions for how to improve SRO effectiveness in the schools.

SUMMARY OF SRO FOCUS GROUP DISCUSSION

All SROs reported that they had volunteered for their assignments. Almost all (11 of the 12) had had significant experience in their jobs, having worked as SROs for between 4 and 10 years.

The SROs in the focus group said that the SRO training appropriately concentrated on much of what they do, even informally. In many ways, the training was said to "take what we do and give it a name." Consistent with this training, the SROs would like to have a broader role in

increasing safety in the schools. They would like to be mentors to help youth, ensure safety, and to "teach kids to be respectful and successful." They also want to educate youth on the role of police and to help improve relations between youth, communities, and police. This public relations role was viewed as important, and almost every SRO in the group desired the role of "Officer Friendly." It is very hard to carry out that role, though, according to SROs in the focus group, because schools have many other issues in play and SROs often are called on to enforce discipline.

The SROs said that they have been able to do some of the safety planning that is supposed to be a part of their role. They mentioned a Mayor's hotline for reporting school safety assessment problems. Yet they felt that they are limited in implementing many of the ideas presented in their training, largely because of other challenges, cultural and structural, presented within the schools. For example, they said that many teachers do not understand the supportive role SROs can take. Teachers often turn to SROs primarily as enforcers of discipline. SROs commented on the inconsistencies of discipline between schools and administrators. Some suggested that school staff should take greater responsibility for monitoring student behavior and enforcing rules with greater strictness and throughout the schools. The SROs suggested that teachers and other school staff might benefit from the SRO training. In addition, the SROs felt that many District public schools are facing other challenges that make their job more difficult. For example, many schools are currently undergoing transitions, such as school consolidations and personnel changes, which, in their opinion, have contributed to disruption in some.

The SROs said that some DC schools appear to be in crisis, independently of the transitions. The incentives for students to come to school, attend classes, study, and learn are often inadequate, and the conditions in some of these schools can be chaotic. SROs often get overwhelmed with day-to-day crises and, as a result, cannot engage in the kinds of proactive mentoring they believe might be helpful to kids who are facing multiple problems at home and at school. They noted that they "do a lot of things that are not in our job description." They develop relationships with students, and some youth even use the terms "Mom" or "Dad" when mentioning specific SROs.

In summary, the SROs in the focus group seemed experienced and highly committed to their work. They felt that the training gave appropriate emphasis on what they are doing and should be doing. To maximize the impact of better training, however, it is clear that the school system and ICSIC will need to continue addressing the larger issues affecting school safety and climate. SROs understood that many youth in District public schools are facing multiple problems in their lives and at school that, if not adequately addressed, can make it virtually impossible for them to succeed as students. They felt that teachers and other school staff should take more of a lead in enforcing discipline and they said that they needed the opportunity to sit down with security and school system personnel to compare notes and try to coordinate activities more effectively. With this shift in focus, SROs would be freed up to function in more positive and supportive roles, and not just as enforcers of discipline. The SROs also said that additional supports likely will be needed, so youth with multiple problems can have a better chance of functioning and succeeding as students.

[*Concluding Note.* In response to the SRO focus group comments, ICSIC staff noted that most of these issues are familiar to the DCPS central office and ICSIC staff and must be part of the larger

conversation about and planning for redesigning and improving school safety and security overall.]

Interviews With Principals at DC START Program Schools

Interviews with the principals at a sample of participating schools were initiated in December and will continue throughout the evaluation over the next five years. Results of the interviews with principals across a sample of schools with evidence-based programs will be presented in the next interim evaluation report and annual evaluation report.

Given the relatively small pilot implementation of the DC START program, the evaluation team was able to reach a majority of the principals from the seven participating schools. Highlights of these interviews follow.

Principals correctly described the target population for DC START as children with behavioral and emotional problems. They reported that teachers and students like the program.

Although most of the principals appear to be quite active in the DC START program, they mostly were unaware of ICSIC or that it was the sponsoring agency. Half of the principals meet regularly with their DC START clinician; others meet as needed. These meetings are generally used for the clinician to update the principal on student progress. The principals correctly described the target population as those children with behavioral and emotional problems or as at-risk learners not in the special education component. For those principals who could speak to the progress of students in DC START, positive results have been seen in some students. Further clarification is needed regarding students who are identified as special education students after they have begun DC START. Also, would students need to leave the DC START program upon receipt of an IEP? The principals reported that teachers like the program and that parents and students have been receptive to it. It was noted that teachers may need more clarity about how to refer children to the program; another meeting with staff may be helpful in this regard. Half of the principals specifically stated that they were glad to have the program at their school. Principals expressed concern about whether schools would continue to have the counselors and clinicians in future years. It was stated that it would be useful to target more of the at-risk learners and provide more family counseling for kids who need it.

Survey of ICSIC Members

A Web-based survey (see appendix D) was developed and a link to the survey was emailed to ICSIC members in late fall 2008. The survey solicits information on their views on ICSIC's contributions to achieving the six citywide goals for children and youth and levels of collaboration between agencies. It also calls for members to describe the most important steps they believe ICSIC could take to improve the relationship between their agency and other agencies that are important for their work and to describe the most important steps that they believe ICSIC could take to improve overall interagency collaboration. The results of the survey and will be presented in the next interim evaluation report.

Summary of Preliminary Findings

The District of Columbia—under the leadership of the Mayor, and with his extensive participation—has initiated and is implementing a very broad, well-structured process, under the supervision of ICSIC, for the selection, implementation, and evaluation of evidence-based programs that have a real chance of making a difference in the lives of the District's children and youth. Because of the regular meetings of ICSIC—with the involvement of the Mayor, the Deputy Mayor for Education, and the key agency heads—this process has a chance of achieving effective interagency collaboration that can bring about real services integration. In addition, the selection and implementation of proven programs and program components increase the likelihood that the results of this effort will be positive.

The ICSIC and the DME can take pride in some major accomplishments so far:

- They have established a serious and credible process, with monthly meetings that involve the Mayor, the Deputy Mayor for Education, and the key child-serving and other agency heads.

- They have maintained the focus of that process on the achievement of broad, crosscutting goals for the District's children and youth.

- They have successfully negotiated a memorandum of understanding among all the participating agencies, to ensure that they will share appropriate data about children and maintain the confidentiality of that information.

- They have successfully identified and begun to implement five evidence-based programs that, in whole or in part, have been widely and rigorously studied, and widely hailed for their excellence and effectiveness.

- They have hired appropriately qualified staff for DC START and Primary Project and successfully begun to train teachers, clinicians, School Resource Officers, and other staff on how best to implement these programs.

- They have provided continuing oversight, hands-on supervision, and onsite technical assistance for those who are working on these programs.

- They have overseen the collection of a variety of preliminary evaluation data, both qualitative and quantitative, which indicate that the processes, the trainings, and the implementation and evaluation of the programs are proceeding well.

- And they have directed the development of a plan for more rigorous evaluation of the ICSIC process and of the implementation and outcomes of the evidence-based programs.

Preliminary Recommendations

At this early stage in the implementation of these programs, several steps should be considered by ICSIC and the District, to ensure the effectiveness of these efforts:

- ICSIC and DME should consider how best to encourage greater engagement on the part of some school administrators, particularly school principals, in the implementation of ICSIC-sponsored programs, especially LifeSkills® Training, Second Step®, and the School Resource Officer programs.

- ICSIC and DME should also continue to seek ways to maintain a high level of support among teachers and other implementers, so that they can maintain appropriate levels of fidelity to the evidence-based programs they are helping to carry out.

- ICSIC should ensure that the experience and voices of frontline staff (e.g., School Resource Officers) continue to be included (perhaps even more than before) in the planning and implementation process. Many of these staff have valuable hands-on experience with the situations faced by different schools, and with the community and family contexts that contribute to school problems.

- ICSIC should consider how to provide stronger direction and coordination for the primary prevention programs—such as Second Step®, LifeSkills®, and the School Resource Officer programs—that are being implemented in many schools.

- After the first round of program implementation has been completed in spring 2009, ICSIC should, where needed, broaden the spectrum of services available in each of the mandated areas and continue to develop services that meet the diverse needs of the District's children and families. The following kinds of additional programs could be considered for implementation: primary prevention programs to increase family resilience, secondary prevention programs to increase school attendance, and tertiary prevention programs especially to reduce truancy and juvenile violence and delinquency.

- ICSIC should seek to identify those schools and school programs that are effectively addressing difficult student, home, school, and community issues and, wherever possible, build on those successes.

5. Plans for Fiscal Year 2009

ICSIC Plans for FY 2009

Interagency Collaboration and Services Integration Commission (ICSIC) programs are currently being implemented in an extensive pilot phase to ensure that expected results are produced and that the programs succeed. This limited scale of implementation is sufficiently expansive to generate results that are measurable and far-reaching yet not so extensive to prohibit attention to critical details such as technical assistance, monitoring problems, the provision of materials, and program support amid school-level administrative changes.

As additional outcome data is produced, a further analysis will be done on the continuation of programs and possible expansion into additional schools and to more students. The Office of the Deputy Mayor for Education is leading the pilot phase of these programs in close consultation and partnership with other ICSIC member agencies. Once the programs become more stable and success is demonstrated, decisions will be made about transferring these programs into the operation plans for other agencies. By piloting the program in a supportive and controlled environment in these schools and communities, ICSIC can ensure that these evidence-based programs produce the high level of outcomes expected.

In addition to planning regarding current programs, ICSIC is currently engaging in conversations about other possible programs to pilot in the next few years and will follow a similar decision-making process. ICSIC will concentrate on broadening the spectrum of services available in each of the mandated areas and continue to develop services that meet the needs of the District's children and families.

Evaluation Plan for FY 2009

This research proposes a sound, feasible, and efficient multifaceted design to assess the effects of the evidence-based programs implemented in the District of Columbia Public Schools (DCPS) by ICSIC. Overall, the major components of the evaluation will assess

1. The ICSIC infrastructure, its processes, its implementation of evidence-based programs, and its sustainability
2. The effects on children of the following, implemented evidence-based programs (EBPs):
    A. DC START
    B. Primary Project
    C. Second Step®
    D. LifeSkills® Training
    E. School Resource Officers

This chapter is divided into the following sections: Research Questions, Process Evaluation, Outcome Evaluation, and Data Sources. Logic models for each of the five programs appear after each program's discussion.

Research Questions

Outcome Evaluation Research Questions

This evaluation of the EBPs will be guided by three sets of research questions related to outcomes: a) questions addressing student-level outcomes, b) questions addressing school-level outcomes, and c) questions addressing community-level outcomes.

The student-level outcomes, primarily applicable to DC START and Primary Project, will be guided by the following research questions:

This evaluation will be guided by research questions related to student-level outcomes, school-level outcomes, and community-level outcomes.

- Do/does DC START and/or Primary Project produce improvement among participating students in their specific target areas?
- Do students who receive higher dosages of DC START and/or Primary Project perform better on the target outcomes than those who receive less service?
- Do/does DC START and/or Primary Project produce improvement among participating students in academic achievement?
- Does DC START produce improvement among participating students in school attendance?
- Do/does DC START and/or Primary Project produce a reduction in school-related discipline incidents?
- What are the characteristics (age, gender, grade, etc.) of students participating in DC START and Primary Project with successful outcomes compared with the characteristics of those with less successful outcomes?
- Do students receiving the LifeSkills® Training curriculum increase in their attitudes, knowledge, and skills related to the content of the curriculum?

The school-level outcomes—applicable to Second Step®, LifeSkills® Training, and School Resource Officers—will be guided by the following research questions:

- Do schools that implement the primary prevention programs show a reduction in school-related discipline incidents?
- Do schools with the primary prevention programs show improvement on items related to safety on DCPS and Youth Risk Behavior Survey (YRBS) surveys?
- Do schools with the primary prevention programs show a decline in delinquency/crime in school and on school grounds?
- Do schools with the primary prevention programs have less student and teacher victimization?
- Do schools with sixth, seventh, and eighth graders receiving LifeSkills® Training show improvement on items related to substance abuse and other high-risk behaviors on DCPS and YRBS surveys?
- Are Crime Prevention Through Environmental Design audits implemented at middle and high schools?

The community-level outcomes will be guided by the following research questions:

- Was a successful infrastructure developed by ICSIC to ensure collaborative decision-making?
- Were there increased coordination, collaboration, and communication among ICSIC members?
- Were the ICSIC programs sustained over time?
- Was there a reduction in crime in areas surrounding school grounds?

Process Evaluation Research Questions

A process evaluation examines the context in which a program is implemented. All facets of program implementation—including staff training, fidelity of implementation, collaboration, program capacity building, and sustainability—are typically covered in a process evaluation.

The following research questions related to the ICSIC EBPs will be addressed by the process evaluation:

- To what level of adherence to the research-based program model is each of the five programs being implemented?
- What type, frequency, and duration of training are provided to staff of the five programs?
- What are the frequency and duration of services implemented at each EBP site?
- What percentage of the target population was reached in each DC START and Primary Project school?
- What barriers to successful implementation were encountered at each EBP site?

Process Evaluation

Fidelity of the Evidence-Based Programs

Because fidelity or adherence to the model is critical to the successful implementation of a program, the evaluation includes fidelity measures.

The degree to which a program achieves its intended outcomes is strongly related to the degree to which it is implemented in accordance with its design. This adherence, known as fidelity to the model, is vitally important to successful program implementation. Research has shown that even an evidence-based program, when poorly implemented, can lead to negative outcomes. An outcome evaluation of Washington State's research-based programs found that programs such as Multisystemic Therapy and Functional Family Therapy (both evidence-based Blueprints Programs), when poorly implemented, may not only fail to reduce recidivism but also may actually increase recidivism (Washington State Institute for Public Policy, 2004).

Procedures will be put in place to measure the fidelity of a sample of each EBP.

Staff training on program protocols and procedures is key to competent EBP implementation. Ongoing training and technical assistance is also important to increase the likelihood that a program

will be implemented as designed. It is hypothesized that students attending programs with high fidelity scores will perform better on various outcome measures than those from programs with low fidelity scores.

Individual clinicians, child associates, teachers, and other staff responsible for delivering programs will be scored on their measure of fidelity to the model based on data from each EBP's respective fidelity instrument. These fidelity scores will be supplemented with information from onsite interviews with program staff, administrators, teachers, referral agency service providers, and other relevant persons.

DSG evaluation staff will be trained in the correct use of the fidelity instruments. After training, DSG evaluators will visit a sample of program sites to complete fidelity instruments. DSG will work in close collaboration with the ICSIC and administrative staff who are responsible for certain fidelity assessment and data collection tasks.

DSG evaluators will conduct interviews with clinicians, clinical supervisors, and others to assess their understanding of the protocols, processes, treatment, referral, and case management techniques.

Specifically, for the DC START program, two main methods will be used to assess fidelity. First, the use of the CHARI database will be assessed by tracking each clinician's number of hours of use of CHARI per week and the types of data entered. Second, two fidelity measures developed and tested by the originators of the model will be used to assess clinician's fidelity to the two interventions used in the model: Child-Centered Play Therapy and Cognitive-Behavioral Therapy.

Fidelity of the other EBPs will be assessed through a) onsite observations, b) interviews with program staff and teachers, c) focus groups with School Resource Officers, teachers, child associates, and clinicians, and d) periodic completion and analysis of each program's implementation checklist instruments at a sample of sites.

Assessment of ICSIC Infrastructure Capacity and Sustainability

DSG will assess the extent to which ICSIC member agencies have developed an infrastructure to involve agency leaders in collaborative decision-making to ensure that ICSIC objectives are achieved. The capacity of ICSIC member agencies to sustain ICSIC programs and activities will also be assessed.

As noted by Frey and colleagues (2005) and many others, assessing collaboration and capacity-building among community partners is often difficult. Valid and reliable instruments are often difficult to design, resulting in problems in identifying meaningful changes in the level and pattern of collaboration. Because of this, we will triangulate the data by using a variety of methods to assess the degree to which the ICSIC members have successfully developed collaborative decision-making.

These methods will include observations and analysis of ICSIC meetings, interviews with the 17 agency representatives, review of meeting actions, and an annual online survey of ICSIC members. The survey was adapted from one used in the Safe Schools/Healthy Students grant programs to assess the success of their collaboration. A copy of this survey appears in appendix D.

Outcome Evaluation

The ICSIC outcome evaluation will be treated as five independent evaluations because of the significant differences among the ICSIC programs. For instance, LST is a classroom-based substance abuse prevention program designed to prevent the early stages of substance use. Second Step®, on the other hand, while still a classroom-based approach, is designed to reduce impulsive and aggressive behavior in children by increasing their social competency skills. The differentiation in design and intent necessitates that different outcomes be used to measure success of each program. The former is designed to impact substance abuse while the latter is designed to reduce aggressive behavior. For example, the success of LST must be measured in terms of its ability to reduce the potential for substance abuse while the success of Second Step® must be measured in terms of its ability to reduce impulsivity and aggressive behavior.

All of the programs will, however, use a single-group pretest/posttest design to assess the effects of each program. This design is one of the most frequently used designs in social science research (Cook and Campbell, 1979). It requires the measurement of outcomes on the same targets before program participation and again sometime after the completion of the program. Comparing these two sets of measures provides a reasonable assessment of the program effect. The main drawback to this design is that the estimate will be biased if it includes the effects of other influences that occur during the study period (Rossi, Lipsey, and Freeman, 2004, 290). This bias is more likely to occur when the time elapsed between the two measurements is large (i.e., a year or longer) because over time it becomes more likely that other processes will obscure any effect of the program. As a result, a simple pretest/posttest design is best suited for short-term assessments of programs attempting to affect conditions that are unlikely to change much on their own. In addition, the design is useful for the routine monitoring where the purpose is mainly to provide feedback to program administrators, not to determine the causal inferences regarding program effects.

> A single-group pretest/posttest design will be used to assess the effects of each program. This study will compare outcomes in the treated targets after completion of the program with outcome measures on the same targets from before the program began.

Two of the programs (DC START and Primary Project) will assess individual-level outcomes while the three other programs (Second Step®, LifeSkills® Training, and School Resource Officer Training) will assess school-level outcomes. **Table 5.1** provides a summary of the outcome measures for each program. **Tables 5.2 and 5.3** provide illustrations of the evaluation strategies for the programs. The following section will briefly describe the sample, expected attrition and the outcomes of each program evaluation.

Table 5.1. ICSIC Study Outcomes			
	2008–09 SCHOOL YEAR ICSIC INTERVENTIONS		
OUTCOMES	**Primary Prevention (Primary)**	**Secondary Prevention (Selective)**	**Tertiary Prevention (Indicated)**
Student-Level Outcomes			
Improved Grades		DC START, Primary Project	
Reduced disciplinary incidents (e.g., suspensions)		DC START, Primary Project	
Improved attendance		DC START, Primary Project	
Improved behaviorally specified target psychosocial and emotional development (e.g., personal development, level of functioning)		DC START	
Improved behaviorally specified target psychosocial and emotional development goals (e.g., task orientation, behavior control, assertiveness)		Primary Project	
School-Level Outcomes			
Reduced truancy	LifeSkills®, Second Step®		
Reduced drug use	LifeSkills®, Second Step®		
Reduced delinquency	LifeSkills®, Second Step®		
Increased feeling of safety	LifeSkills®, Second Step®		
Reduced fights on school grounds	LifeSkills®, Second Step®, School Resource Officers		
Reduced crime on school property	School Resource Officers		
Reduced weapon carrying	LifeSkills®, Second Step®, School Resource Officers		
Improved school climate	LifeSkills®, Second Step®, School Resource Officers		
CPTED improvements made	School Resource Officers		
Community-Level Outcomes			
Infrastructure in place to ensure collaborative decision-making	ICSIC		
Capacity in place by ICSIC members to sustain ICSIC programs and activities	ICSIC		
Reduced crime in areas surrounding school grounds	SROs		
Increased coordination	ICSIC		
Increased collaboration	ICSIC		
Increased communication	ICSIC		

Table 5.2. Secondary Intervention Program Implementation

	School Year 2007–08				School Year 2008–09												School Year 2009–10											
Program	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
DC Start	P	X_1	→	→	→	⇢	→	→	→	→	→	→	→	→	→	→	⇢	⇢	→	→	→	→	→	→	→	→	→	→
					P	X_2	→	→	→	→	→	→	→	→	→	→	⇢	→	→	→	→	→	→	→	→	→	→	→	→
Primary Project							P	P	P	P	Y_1	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	→	

Program Information

DC START = Continuous enrollment and intervention of 21 weekly sessions

Primary Project = Continuous enrollment and intervention of 15 weekly sessions

Program Activities

P= Preparation activities including meetings, hiring, staff training, and technical assistance.

X_1 = DC START referral and enrollment of children begins for two clinicians.

X_2 = DC START referral and enrollment of children begins for five additional clinicians.

~~Y_2~~ → Primary Project referral and enrollment of children begins for child associates

→ Ongoing program activities.

⇢ Reduced program activities during summer.

Table 5.3. Primary Prevention Program Implementation

Program	Pre-Implementation		School Year 2008–09				School Year 2009–10				School Year 2010–11				School Year 2011–12				School Year 2012–13			
	Sp 07	Su 08	F	W	Sp	Su	F	W	Sp	Su	F	W	Sp	Su	F	W	Sp	Su	F	W	Sp	Su
Second Step®	T_0	P	X		T_1												T_2					
LifeSkills® Training	T_0	P	X		T_1												T_2					
School Resource Officers	T_0	P	X		T_1												T_2					

Program Period

W = Winter
Sp = Spring
Su = Summer
F = Fall

Program Information

Second Step® = Primary prevention (continuous)
LifeSkills® = Primary prevention (continuous)
SRO = Primary prevention (continuous)

Program Activities

P = Preparation activities including meetings, school selection training staff.
X = Program implementation begins.
→ = Ongoing program activities.
T_0 = Baseline (YRBS) was administered prior to program implementation in 2007 and will be re-administered every two years. The YRBS is used to measure school level outcomes.
T_1 = Follow-Up 1 (the 2009 Youth Risk Behavior Survey). ⟹
T_2 = Follow-Up 2 (the 2011 Youth Risk Behavior Survey).

DC START

DC START is a school-based, secondary intervention that serves a client population of elementary school-aged children with complex service needs in order to promote positive social, emotional, and educational development. An illustration of the program model, which presents the activities, output measures, and outcome metrics, is provided on the next page.

SAMPLE

DC START is being implemented in the following seven schools:

1. Barnard Elementary School
2. Leckie Elementary School
3. Malcolm X Elementary School
4. Simon Elementary School
5. Truesdell Educational Center
6. Martin Luther King Jr. Elementary School
7. MacFarland Middle School

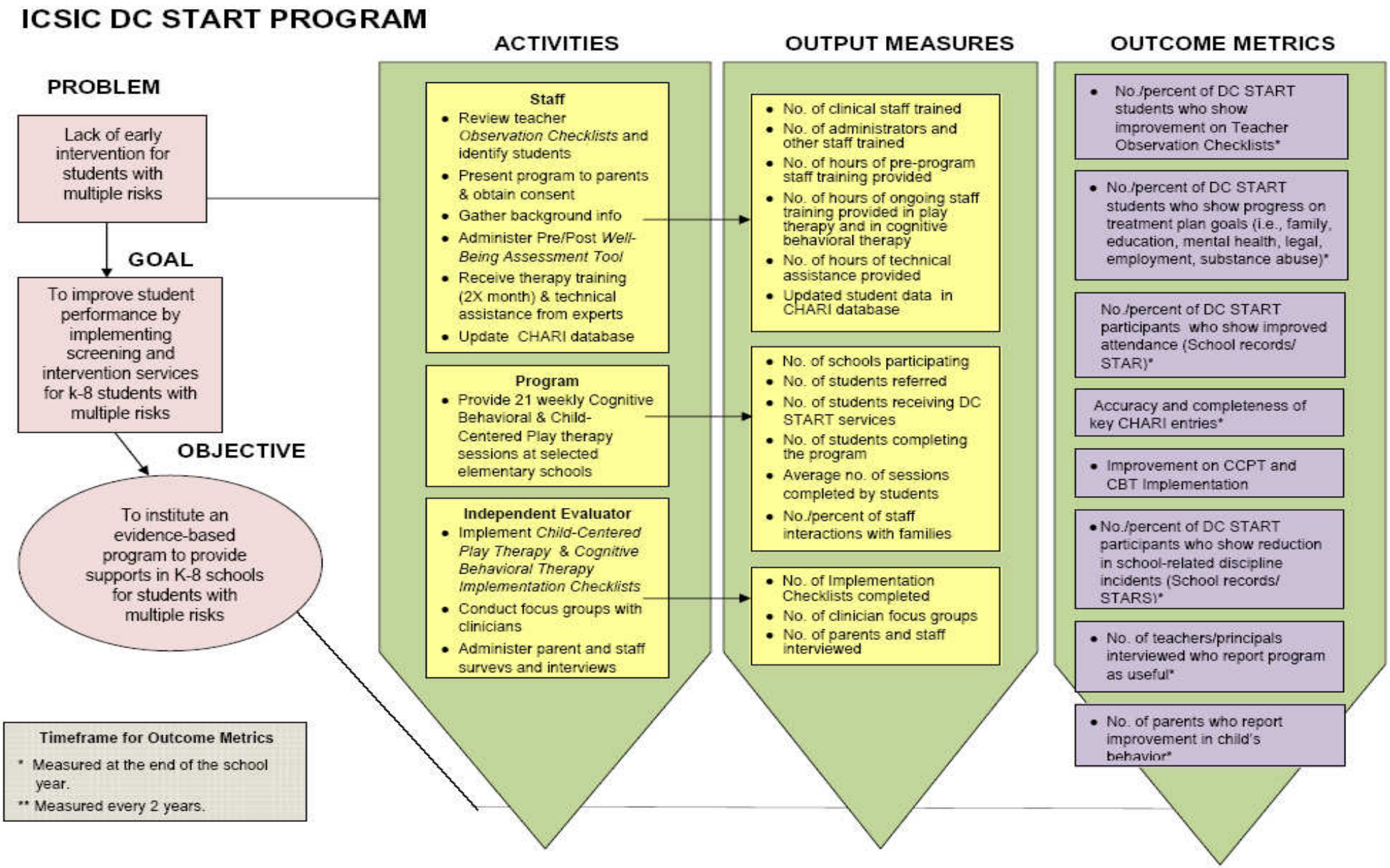
The 2008–09 school year study sample will be drawn from all seven schools. Each school has a single clinician who serves 20–25 youth for a 21-week period. The length of the program typically enables a clinician to serve two cohorts a year. Using a conservative estimate of 20 youth per cohort, a single clinician will serve 40 youth a year. Thus, in the 2008–09 school year, the estimated sample size of the DC START program will be 280 youth (40 youth x 7 schools). Clearly, this figure will grow exponentially as additional schools are included in the DC START program and subsequent cohorts are added to the sample.

ATTRITION

It is likely that the study will lose some youth through attrition. The reasons for attrition may range from relocation, dissatisfaction with the program, dropping out of school, expulsion from school, or even death. Fortunately, the posttest period will immediately follow program completion and not be protracted over a long period of time, thus reducing the potential for attrition. From a total sample of 280, we conservatively expect to lose 20 percent to attrition at the posttest. Therefore, the estimated full sample size resulting from attrition is 224.

OUTCOMES

The outcome evaluation will assess individual program participant improvements in personal development. The factors that affect personal development are categorized into three major domains (personal development, environmental influences and level of functioning) and across four contexts: individual, school, family, and community. (See **table 5.1** for a list of study outcomes by program.)


ICSIC DC START PROGRAM
PROBLEM
Lack of early intervention for students with multiple risks
GOAL
To improve student performance by implementing screening and intervention services for k-8 students with multiple risks
OBJECTIVE
To institute an evidence-based program to provide supports in K-8 schools for students with multiple risks
ACTIVITIES
Staff
Review teacher Observation Checklists and identify students
Present program to parents & obtain consent
Gather background info
Administer Pre/Post Well-Being Assessment Tool
Receive therapy training (2X month) & technical assistance from experts
Update CHARI database
Program
Provide 21 weekly Cognitive Behavioral & Child-Centered Play therapy sessions at selected elementary schools
Independent Evaluator
Implement Child-Centered Play Therapy & Cognitive Behavioral Therapy Implementation Checklists
Conduct focus groups with clinicians
Administer parent and staff surveys and interviews
OUTPUT MEASURES
No. of clinical staff trained
No. of administrators and other staff trained
No. of hours of pre-program staff training provided
No. of hours of ongoing staff training provided in play therapy and in cognitive behavioral therapy
No. of hours of technical assistance provided
Updated student data in CHARI database
No. of schools participating
No. of students referred
No. of students receiving DC START services
No. of students completing the program
Average no. of sessions completed by students
No./percent of staff interactions with families
No. of Implementation Checklists completed
No. of clinician focus groups
No. of parents and staff interviewed
OUTCOME METRICS
No./percent of DC START students who show improvement on Teacher Observation Checklists*
No./percent of DC START students who show progress on treatment plan goals (i.e., family, education, mental health, legal, employment, substance abuse)*
No./percent of DC START participants who show improved attendance (School records/ STAR)*
Accuracy and completeness of key CHARI entries*
Improvement on CCPT and CBT Implementation
No./percent of DC START participants who show reduction in school-related discipline incidents (School records/ STARS)*
No. of teachers/principals interviewed who report program as useful*
No. of parents who report improvement in child's behavior*
Timeframe for Outcome Metrics
* Measured at the end of the school year.
** Measured every 2 years.

Primary Project

The Primary Project is a school-based early intervention and prevention program that addresses the social and emotional needs of children in kindergarten through third grade who have social or emotional school-adjustment difficulties (but not serious dysfunction). The program logic model, which presents the activities, output measures, and outcome metrics, is provided on the next page.

SAMPLE

Primary Project is being implemented in 12 schools:

1. Aiton Elementary School
2. Browne Educational Center (PK–8)
3. Burrville Elementary School
4. Garrison Elementary School
5. Harriet Tubman Elementary School
6. M.C. Terrell/McGogney Elementary School
7. Meridian Public Charter School (ECU–8)
8. Miner Elementary School
9. Stanton Elementary School
10. Thurgood Marshall Educational Center (PK–8)
11. Turner Elementary School
12. Webb/Wheatley Elementary School

Beginning in January 2009, the 2008–09 school year study sample will include all 12 schools. Most schools will have a team of two child associates who will serve approximately 20–25 youth for a 15-week period. The program length typically enables the team to serve two cohorts a year. Using a conservative estimate of 20 youth per cohort, a treatment team will serve approximately 40 youth a year. Because the program is starting in January 2009, the estimated sample size for the 2008–09 school year will be 240 youth (20 youth x 12 schools); the estimated sample size for the following years will be 480 youth (40 youth x 12 schools).

ATTRITION

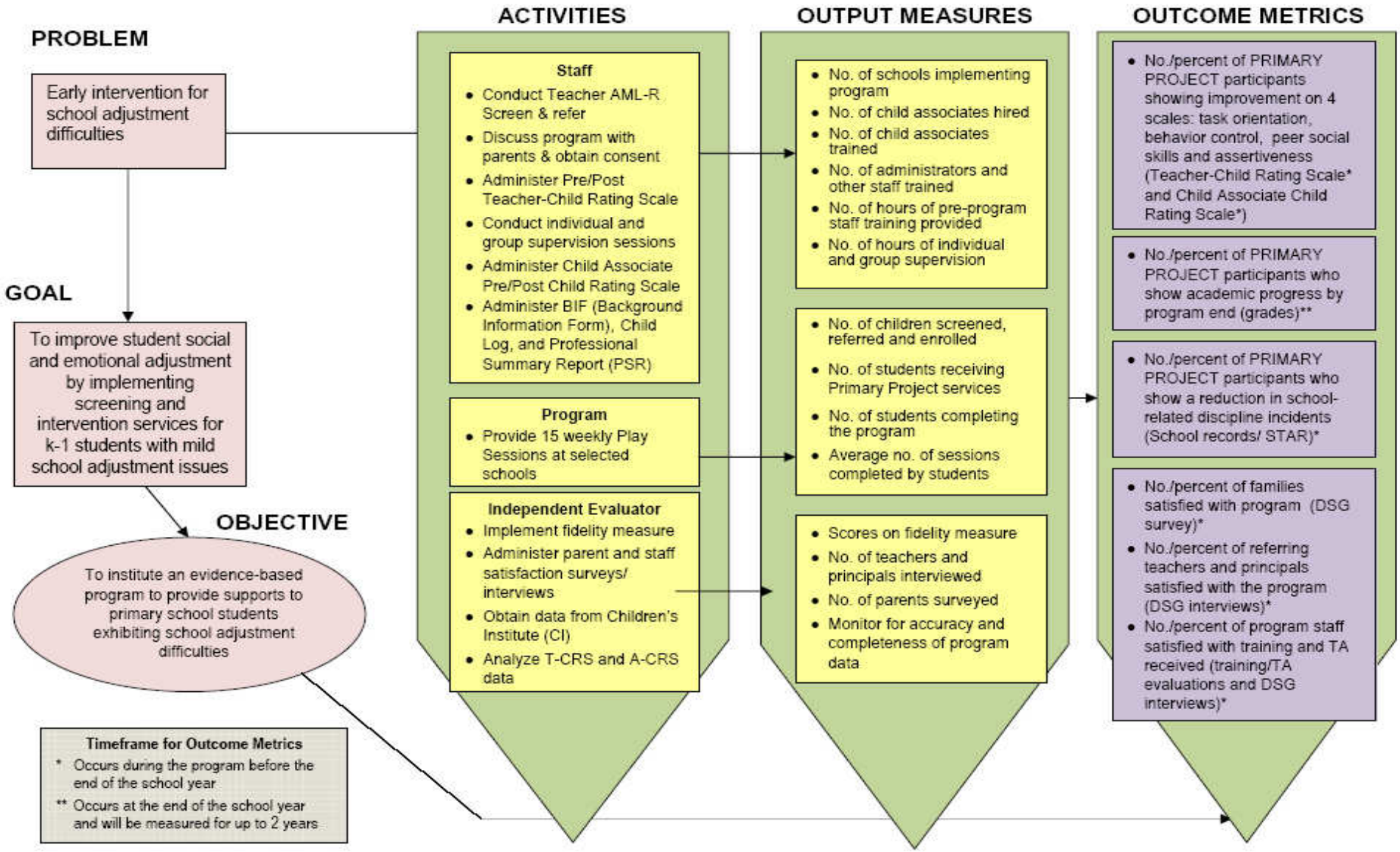
Again, it is likely that the study will lose some youth through attrition. From a total sample of 480, we conservatively expect to lose 20 percent to attrition at the posttest. Therefore, the estimated full sample size resulting from attrition is 384.

OUTCOMES

The outcome evaluation will assess individual program participant improvements in 1) task orientation; 2) behavior control; 3) adaptive assertiveness; 4) peer sociability. Task orientation incorporated such factors as learning difficulty, tolerance for frustration, willingness to follow school rules, and disruptive behavior. Behavior control incorporated such factors as "acting out," aggression, tolerance for frustration, willingness to follow school rules, and disruptive behavior. Adaptive assertiveness incorporated assertiveness in social situations (including sharing opinions) and in comparison with shyness and anxiety. Peer sociability incorporates factors such as peer sociability,

improved quality of peer relationships, and improved social skills. (See **table 5.1** for a list of study outcomes by program.)

ICSIC PRIMARY PROJECT



Second Step®

Second Step® is designed to reduce impulsive and aggressive behavior in children by increasing their social competency skills. It is being implemented in a minimum of 12 schools and up to 16 schools. An illustration of the program logic model, which presents the activities, output measures, and outcome metrics, is provided on the next page.

SAMPLE

The 2008–09 school year study *sample* will include all schools where it is being implemented (a minimum of 12 schools). As more teachers participate in the training, additional schools will implement the program and be added to the sample. While DC START and the Primary Project focus on the problems of individual youth, Second Step® is a primary prevention program that addresses schoolwide behavioral issues where all lessons are designed to establish clear schoolwide rules and expectations for general behavior. As a result, the unit of analysis is the school rather than the individual youth. The current sample includes 12 of the following schools:

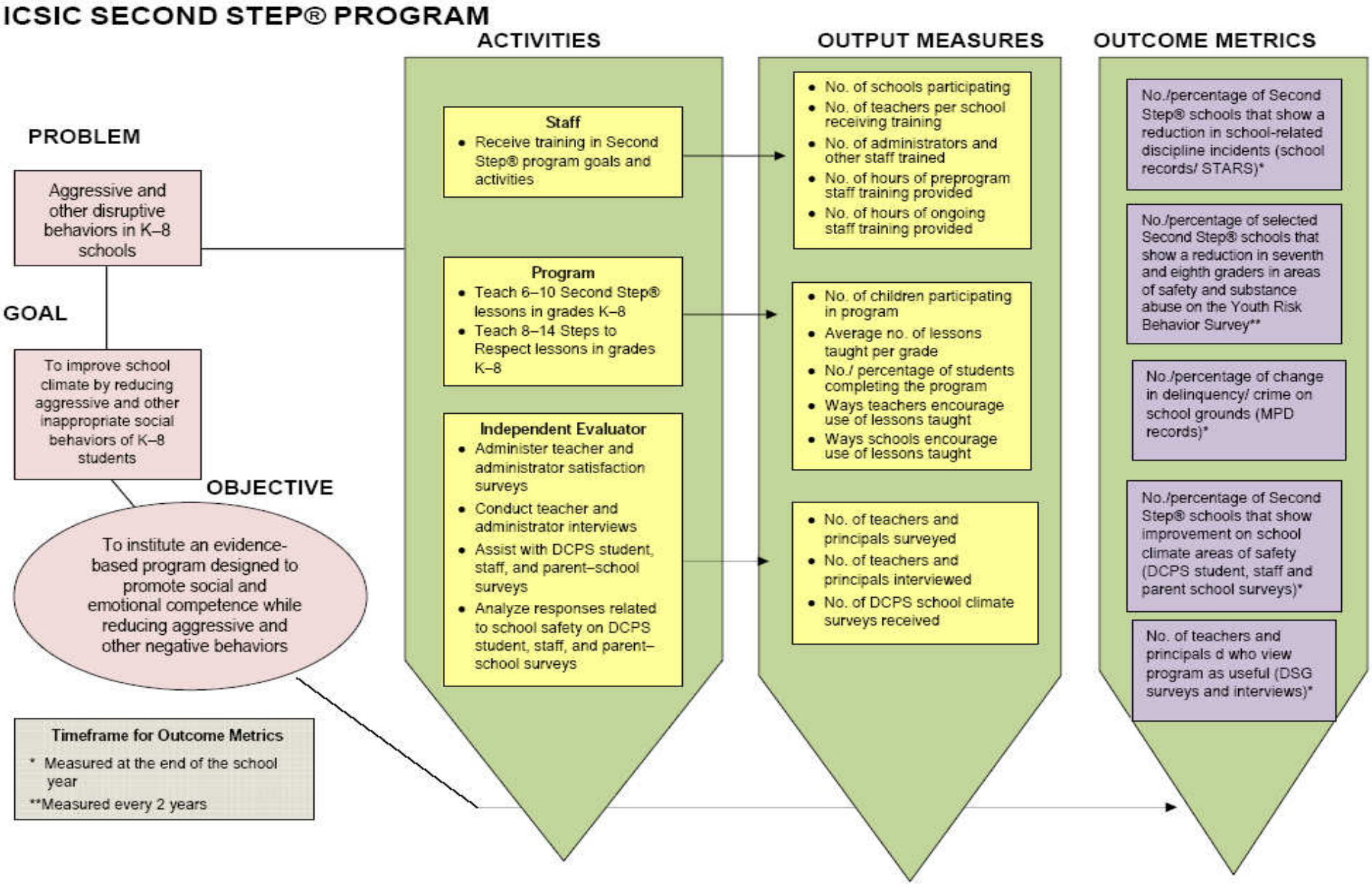
1. Brightwood Educational Center
2. Browne Educational Center
3. Burroughs Educational Center (PK–8)
4. Emery Educational Center
5. Francis–Stevens Educational Center
6. Langdon Educational Center
7. LaSalle–Backus Educational Center
8. Marshall Educational Center
9. Noyes Educational Center
10. Raymond Educational Center
11. Shaed Educational Center
12. Takoma Education Center (PK–8)
13. Truesdell Educational Center
14. Walker–Jones/R.H. Terrell Educational Center
15. West Educational Center
16. Whittier Educational Center

ATTRITION

Not applicable.

OUTCOMES

The outcome evaluation will assess school improvements in 1) the number of school-related discipline incidents; 2) the number of delinquent crimes on school grounds; and 3) school climate. (See **table 5.1** for a list of study outcomes by program.)


ICSIC SECOND STEP® PROGRAM
PROBLEM
Aggressive and other disruptive behaviors in K–8 schools
GOAL
To improve school climate by reducing aggressive and other inappropriate social behaviors of K–8 students
OBJECTIVE
To institute an evidence-based program designed to promote social and emotional competence while reducing aggressive and other negative behaviors
Timeframe for Outcome Metrics
* Measured at the end of the school year
**Measured every 2 years
ACTIVITIES
Staff
• Receive training in Second Step® program goals and activities
Program
• Teach 6–10 Second Step® lessons in grades K–8
• Teach 8–14 Steps to Respect lessons in grades K–8
Independent Evaluator
• Administer teacher and administrator satisfaction surveys
• Conduct teacher and administrator interviews
• Assist with DCPS student, staff, and parent–school surveys
• Analyze responses related to school safety on DCPS student, staff, and parent–school surveys
OUTPUT MEASURES
• No. of schools participating
• No. of teachers per school receiving training
• No. of administrators and other staff trained
• No. of hours of preprogram staff training provided
• No. of hours of ongoing staff training provided
• No. of children participating in program
• Average no. of lessons taught per grade
• No./ percentage of students completing the program
• Ways teachers encourage use of lessons taught
• Ways schools encourage use of lessons taught
• No. of teachers and principals surveyed
• No. of teachers and principals interviewed
• No. of DCPS school climate surveys received
OUTCOME METRICS
No./percentage of Second Step® schools that show a reduction in school-related discipline incidents (school records/ STARS)*
No./percentage of selected Second Step® schools that show a reduction in seventh and eighth graders in areas of safety and substance abuse on the Youth Risk Behavior Survey**
No./percentage of change in delinquency/ crime on school grounds (MPD records)*
No./percentage of Second Step® schools that show improvement on school climate areas of safety (DCPS student, staff and parent school surveys)*
No. of teachers and principals d who view program as useful (DSG surveys and interviews)*

LifeSkills® Training

LifeSkills® Training (LST) is a classroom-based tobacco, alcohol, and drug abuse prevention program for middle school students. It is being implemented in all middle schools. An illustration of the program logic model, which presents the activities, output measures, and outcome metrics, is provided on the next page.

SAMPLE

Staff from the following schools received training in summer or fall 2008:

1. Bell High School
2. Brightwood Educational Center
3. Browne Educational Center
4. Burroughs Educational Center
5. Cardozo High School
6. Deal Middle School
7. Draper Elementary School
8. Eliot–Hine Middle School
9. Emery Educational Center
10. Francis–Stevens Educational Center
11. Hardy Middle School
12. Hart Middle School
13. Jefferson Middle School
14. Johnson Middle School
15. Kelly Miller Middle School
16. Kramer Middle School
17. Langdon Educational Center
18. LaSalle–Backus Educational Center
19. Lincoln Middle School
20. MacFarland Middle School
21. Marshall Educational Center
22. Noyes Educational Center
23. Oyster–Adams Bilingual School
24. Randle Highlands Elementary School
25. Raymond Educational Center
26. Shaed Educational Center
27. Shaw at Garnet–Patterson Middle School
28. Sousa Middle School
29. Stuart–Hobson Middle School
30. Takoma Educational Center
31. Walker–Jones/R.H. Terrell Educational Center
32. Webb/Wheatley Elementary School
33. West Educational Center
34. Whittier Educational Center

Like Second Step®, LifeSkills® Training is a primary prevention program being delivered schoolwide. The focus of the program is to target a broad range of individuals who have not yet initiated substance use in order to prevent the early stages of substance use by influencing risk factors associated with substance abuse. The unit of analysis is the school. The 2008–09 school year *sample size* will be 10 schools. Again, the number of schools is expected to increase in subsequent years of the program as more staff are trained.

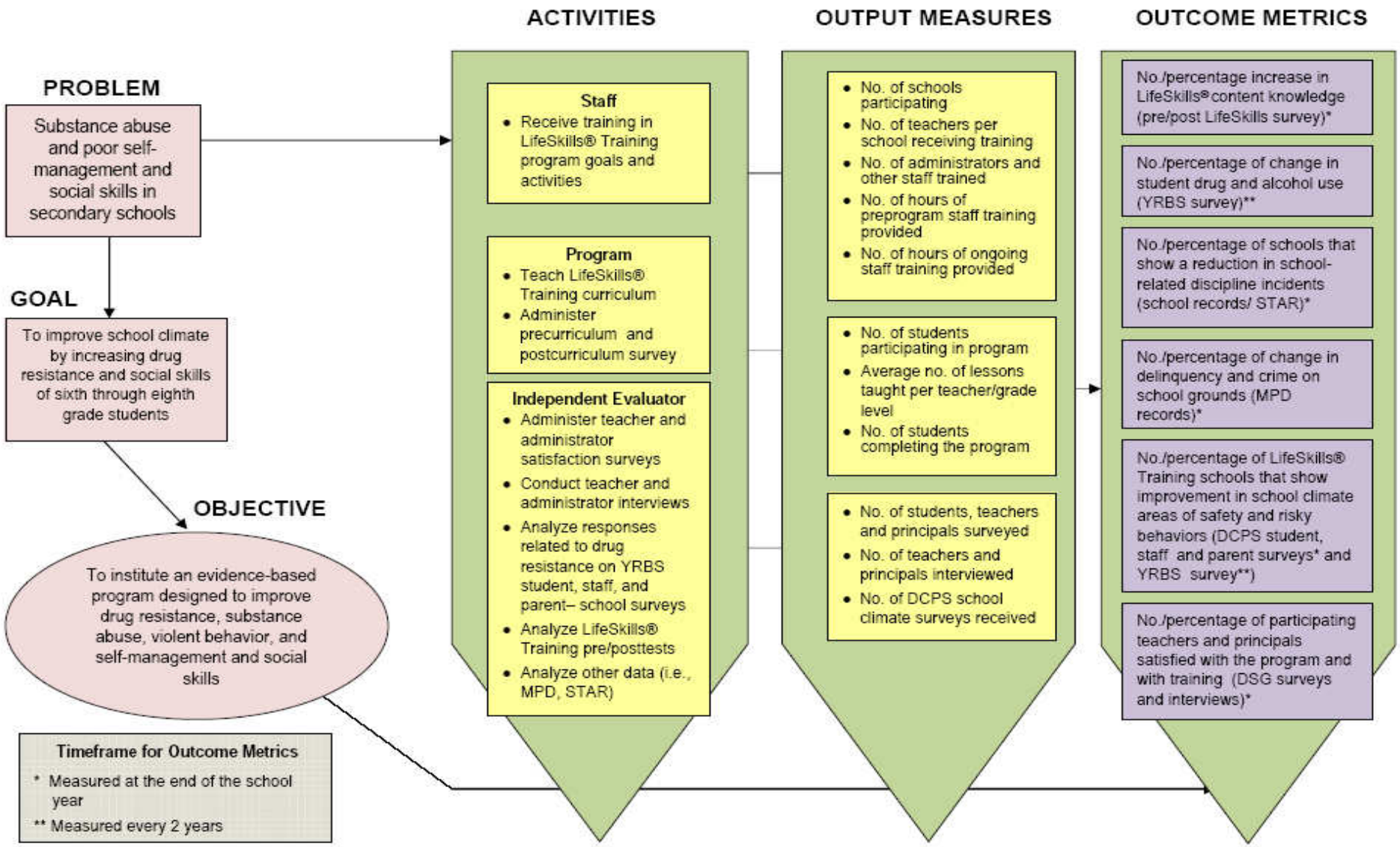
ATTRITION

Not applicable.

OUTCOMES

The outcome evaluation will assess school improvements in 1) substance use; 2) the number of school-related discipline incidents; 3) the number of delinquent crimes on school grounds; and 4) school climate. (See **table 5.1** for a list of study outcomes by program.)

ICSIC LIFESKILLS® TRAINING PROGRAM



School Resource Officer Program

The School Resource Officer (SRO) program involves the placement of a law enforcement officer in the educational environment. The officer is involved in a variety of prevention functions while in the school. All SROs are trained in Crime Prevention Through Environmental Design (CPTED), mentoring and law-related education. An illustration of the program logic model, which presents the activities, output measures, and outcome metrics, is provided on the next page.

SAMPLE

Training was conducted for SROs placed in the 42 schools listed below in the fall of 2008. The 2008–09 school year study will include a *sample* of 15 schools. Again, like Second Step® and LifeSkills®, the SRO program is a schoolwide program. The focus of the program is for the SROs to assist in planning and maintaining school safety with preventive policing techniques, safety audits, law-related education in the classroom, and mentorship. The unit of analysis is the school. The sample will be drawn from the following schools (the number in parentheses shows the number of SROs per school)*:

1. Anacostia Senior High School (4)
2. Ballou Senior High School (4)
3. Ballou STAY (High) School (1)
4. Banneker Senior High School (1)
5. Bell High School (4)*
6. Browne Educational Center (1)
7. Cardozo Senior High School (5)
8. Choice Academy Middle School/Senior High School (1)
9. Coolidge Senior High School (4)
10. Deal Middle School (2)
11. Dunbar Senior High School (4)
12. Eastern Senior High School (4)
13. Eliot–Hine Middle School (2)
14. Ellington School of Arts (1)
15. Francis–Stevens Educational Center (1)
16. Hamilton Center [Special Education] (1)
17. Hardy Middle School (1)
18. Hart Middle School (3)
19. Jefferson Middle School (2)
20. Johnson Middle School (3)
21. Kelly Miller Middle School (2)
22. Kramer Middle School (2)
23. LaSalle–Backus Education Center (2)
24. Lincoln Middle School (4)*

*According to the Metropolitan Police Department, these numbers are subject to change.

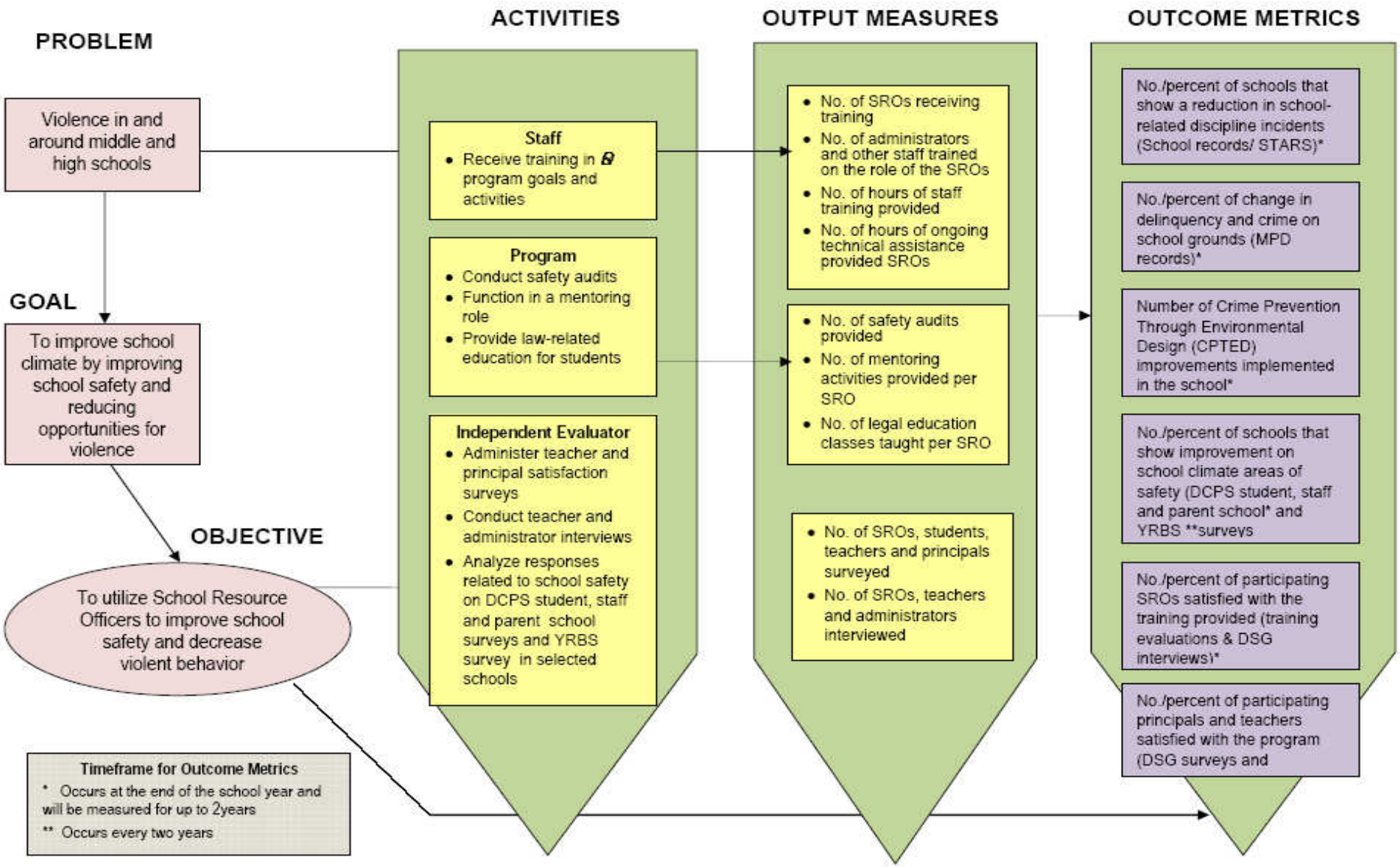
25. Luke C. Moore Academy Senior High School (1)
26. Marshall Educational Center (1)
27. MacFarland Middle School (2)
28. McKinley Technology High School (2)
29. Phelps Architecture, Construction, and Engineering High School (1)
30. Ronald H. Brown Middle School (2)
31. Roosevelt Senior High School (3)±
32. School Without Walls Senior High School (1)
33. Shaw at Garnet–Patterson Middle School (3)
34. Spingarn Senior High School (3)
35. Spingarn STAY (High) School (1)
36. Sousa Middle School (2)
37. Stuart–Hobson Middle School (1)
38. Takoma Educational Center (1) ±
39. Walker–Jones/R.H. Terrell Educational Center (2)
40. Wilson Senior High School (4)
41. Winston Educational Center (2)
42. Woodson at Fletcher–Johnson Senior High School (4)

*Sharing School Resource Officers
±Sharing School Resource Officers

ATTRITION
Not applicable.

OUTCOMES
The outcome evaluation will assess school improvements in 1) the number of school-related discipline incidents, 2) the number of delinquent crimes on school grounds, 3) the number of CPTED improvements implemented, and 4) school climate. (See **table 5.1** for a list of study outcomes by program.)

ICSIC SCHOOL RESOURCE OFFICER (SRO) PROGRAM



Data Sources

Six primary data sources will be used to measure outcome variables. Two types of sources (Children At-Risk Interagency [CHARI] database and individual program instruments), provide student-level data, while the other four types of sources (DCPS STARS database; Metropolitan Police Department (MPD) data; District of Columbia Public School (DCPS) surveys; and the Youth Risk Behavior Survey) provide school-level data. All project-related data will be transferred to DSG at the end of each school year. **Table 5.4** presents a Data Sources by Outcomes chart that summarizes the study measures and data sources for all aspects of the study. Please see appendix D for copies of individual program instruments and surveys used as data sources.

Student-Level Data

CHILDREN AT-RISK INTERAGENCY (CHARI) DATABASE

The CHARI application was developed by the Partnership for Results program for clinicians to record information on a regular basis about their clients. Clinicians in the DC START program have been trained to complete paperwork about their clients and enter it into the database. CHARI offers a single point of assessment and accountability for entering information and analyzing results. Clinicians enter information when the case is first opened, and record progress notes on a regular basis. The initial information includes demographic, family and education data; the regularly updated information is categorized into areas such as treatment plan and goals, service referrals, alcohol/substance abuse, mental health and medical events. Data from the following forms are entered into CHARI:

- *Universal Information Form*—for family demographic and contact information
- *Youth Checklist*— completed by youth and caregiver for background information on the child or youth
- *Exposure to Violence Form*—for documenting the child/youth's exposure to violence
- *Youth Pediatric Symptom Checklist* (Y–PSC)— used by the clinician to score the youth checklist
- *Personal Experience Screening Questionnaire (PESQ)* used if the youth is a substance abuser—is filled out 45 days after a case opens and then a second time at closing
- *Well-Being Assessment Instrument* (Well–BAT)

Fidelity to the model will be measured through the CHARI database as well as through the Child-Centered Play Therapy Implementation Checklist and the CBP Fidelity Checklist.

INDIVIDUAL PROGRAM INSTRUMENTS

Most of the ICSIC programs have their own validated evaluation (i.e., pre and posttests, parent surveys, and teacher surveys), and fidelity instruments. This is necessary because each program is designed to produce different outcomes. For instance, the main objectives of the Primary Project are to detect school adjustment difficulties, prevent social and emotional problems, and enhance learning skills. Progress is assessed during regular meetings between the child associate and school mental health professionals, as well as during midintervention progress reviews. Rating forms (pretest and posttest questionnaires) are used to assess four primary competency areas: task orientation; behavior control; assertiveness, and peer social skills. The evaluation measures include the AML Behavior Rating Scale, the Background Information Form, Teacher–Child Rating Scale, Associate–Child Rating Scale, child log, and Professional summary report. All of the PP instruments will be scored by the Children's Institute in New York. (See samples of all instruments in appendix D.)

On the other hand, the main objectives of LifeSkills® Training (LST) are to enhance the youth's drug resistance skills, personal self-management skills, and general social skills. Its effectiveness is measured by providing students with the necessary skills to resist social pressures to drink alcohol, smoke cigarettes, or use drugs; helping students develop greater self-esteem, self-mastery, and self-confidence; increasing students' knowledge of the immediate consequences of substance abuse; equipping students' tools to effectively cope with social anxiety; and enhancing students' cognitive and behavioral competency to prevent and reduce a variety of health risk behaviors. Evaluation instruments (pretest and posttest questionnaires) are designed to measure the program's effectiveness for each individual group of outcomes.

School-Level Data

STARS DATABASE

The DCPS school system's STARS database will be used to provide school-level outcome data, including grades, attendance, and truancy data.

DISTRICT OF COLUMBIA PUBLIC SCHOOLS STAFF SURVEY

The DCPS Staff Survey provides all staff members at every DCPS school the opportunity to provide valuable feedback. The survey measures staff satisfaction with the district services and schools, obtain staff feedback on school climate and safety, and identify staff needs so that they have the support they need to raise student achievement levels. The survey was developed by the American Institutes for Research (AIR). DSG will work with DCPS and add several school climate questions to this survey when it is administered in May 2009. The survey can be completed online. A copy of last year's survey is located in appendix D.

DISTRICT OF COLUMBIA PUBLIC SCHOOLS PARENT/GUARDIAN SURVEY

The DCPS Parent/Guardian Survey is a confidential survey of all District of Columbia parents and/or guardians. The survey is used by school officials to understand the experiences and level of satisfaction of parents/guardians with District of Columbia Public Schools. It takes approximately 15 minutes to complete. While DSG will add several school program satisfaction and school climate questions to this survey when it is administered in May 2009, the current survey includes questions regarding the following topics:

- Parent demographics
- Satisfaction with the school
- Satisfaction with the school district
- School–parent communication activities
- Involvement with school activities and organizations

A copy of last year's survey is located in appendix D.

DISTRICT OF COLUMBIA PUBLIC SCHOOLS STUDENT SURVEY

The DCPS Student Survey is a confidential survey of all District of Columbia students in 7th through 12th grades. It helps school administrators understand what students think about their schools and how to make them better. The survey is administered every spring. It takes approximately 20 minutes to complete. The current survey includes questions regarding the following topics:

- Student demographics
- Perception of school safety
- Satisfaction with the school
- Satisfaction with the principal
- Satisfaction with teachers
- Access to technology
- General views about the school
- Participation in extracurricular activities

DSG will work with DCPS to add questions to the student survey in those years that the Youth Risk Behavior Survey is not being administered in the schools. We will develop additional questions for this survey and obtain any other consents that may be required. A copy of last year's survey is located in appendix D.

YOUTH RISK BEHAVIOR SURVEY

The Youth Risk Behavior Surveillance System (YRBSS) monitors priority health-risk behaviors and the prevalence of obesity and asthma among youth and young adults. The YRBSS includes a national school-based survey conducted by the Centers for Disease Control and Prevention (CDC) and State, territorial, tribal, and local surveys conducted by State, territorial and local education and health agencies and tribal governments. The YRBS was administered most recently in 2007 (baseline) and is conducted every two years in a sample of schools. The survey includes questions on feelings of safety on school grounds, fighting and bullying at school, victimization at school, weapons carrying by students on school property, fighting on school property, and alcohol and drug use. (See copy of the 2009 Middle School YRBS in appendix D).

DSG is working with Westat, the contractor that is implementing the YRBS survey in the DC schools in spring 2009, to try to ensure that it is implemented in DC schools that are implementing ICSIC programs, so the data can be used to assess school-level outcomes. DSG is also working to ensure access to this data, and to ensure that additional questions (in addition to the core questions) will be included in the YRBS. This procedure is currently in process at the time this report was completed.

Community-Level Data

ICSIC Member Survey

A Web-based survey was developed and a link was emailed to ICSIC members in fall 2008 and will be repeated annually. The survey solicits information on their views on ICSIC's contributions to achieving the six citywide goals for children and youth and levels of collaboration between agencies. It also calls for members to describe the most important steps they believe ICSIC could take to improve the relationship between their agency and other agencies that are important for their work and to describe the most important steps that they believe ICSIC could take to improve overall interagency collaboration.

Focus Groups and Interviews

In fall 2008, focus groups were held with School Resource Officers and DC START clinicians. These focus groups and other focus groups with teachers will be repeated annually. In addition, interviews were held with principals from a sample of schools implementing EBPs and these interviews will be repeated periodically throughout the evaluation.

Metropolitan Police Department Data

Arrest data from the Metropolitan Police Department will be used to assess the degree to which students have committed delinquent acts on school grounds and the surrounding school area. When available, data may also be obtained from school security offices to get additional crime on school grounds information. This data will be obtained annually.

Table 5.4 presents a summary of the data sources discussed above for each level of outcome.

Table 5.4. Outcome Measures and Data Sources	
Student-Level Outcomes	**Data Sources**
Improved grades	STARS
Reduced disciplinary incidents (i.e., suspensions)	STARS
Improved attendance	STARS
Improved behaviorally specified target psychosocial and emotional development (i.e., personal development. level of functioning)	CHARI; Well–BAT; Pediatric Symptoms Checklist; PES–Q
Improved behaviorally specified target psychosocial and emotional development goals (i.e., task orientation, behavior control, assertiveness, and peer social skills)	Teacher–Child Rating Scale; Associate–Child Rating Scale
School-Level Outcomes	**Data Sources**
Reduced truancy	STARS
Reduced drug use	YRBS
Reduced delinquency	YRBS
Increased feeling of safety	YRBS; DCPS student, parent, and staff surveys
Reduced fights on school grounds	MPD
Reduced crime on school property	MPD
Reduced weapon carrying	YRBS
Improved school climate	DCPS student, parent, and staff surveys
CPTED improvements made	Interviews with principals and SROs
Community-Level Outcomes	**Data Sources**
Infrastructure in place to ensure collaborative decision-making	Interviews with ISCIC members; analysis of ICISIC meetings
Capacity in place by ICSIC members to sustain ICSIC programs and activities	Interviews with ISCIC members; analysis of ICISIC meetings
Reduced crime in areas surrounding school grounds	Metropolitan Police Department Reports
Increased coordination	ICSIC survey
Increased collaboration	ICSIC survey
Increased communication	ICSIC survey